Central Bedfordshire Shadow Health and Wellbeing Board

Agenda

Meeting Title:	Central Bedfordshire Shadow Health and Wellbeing Board
Date:	Thursday, 31 January 2013
Time:	1.00 p.m.
Location:	Council Chamber, Priory House, Monks Walk, Shefford

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

2. **Chairman's Announcements and Communications**

   To receive any announcements from the Chairman and any matters of communication.

3. **Minutes**

   To approve as a correct record the Minutes of the last meeting held on 8 November 2012 and note actions taken since that meeting.

Business

Item	Subject	Page Nos.	Lead
4.	**Health and Wellbeing Strategy** To consider and approve the final Joint Health and Wellbeing Strategy 2012-2016.	9 - 30	MS
5.	**Bedfordshire Clinical Commissioning Group (BCCG) Commissioning Intentions** To note the commissioning intentions for BCCG for 2013/14 and receive an update on authorisation.	31 - 80	DG
6.	**The Implications of the Troubled Families Programme on the NHS** To comment on: 6a) which is the briefing note on the Troubled Families presented by Cllr Stay; 6b) which is to consider and comment on the implications of the programme on the NHS.	81 - 90	EG

7.	**Health Inequalities in Central Bedfordshire**	91 - 138	MS
	To consider the Health Inequalities in Central Bedfordshire Public Health Report, its recommendations and suggested actions to ensure implementation.		
8.	**Report from LINk**	139 - 150	BS
	To receive a report from LINk on visits to Care/Nursing Homes in Central Bedfordshire and note LINk's contribution to the emerging Central Bedfordshire Healthwatch.		
9.	**Work Programme**	151 - 160	RC
	To consider and approve the work plan.		

To: Members of the Central Bedfordshire Shadow Health and Wellbeing Board

Mr G Alderson	Director of Sustainable Communities, Central Bedfordshire Council
Dr J Baxter	Director, Bedfordshire Clinical Commissioning Group
Mrs C Bonser	Bedfordshire Local Involvement Network
Mr R Carr	Chief Executive, Central Bedfordshire Council
Dr F Cox	Chief Executive Bedfordshire & Luton PCT Cluster
Mrs E Grant	Deputy Chief Executive / Director of Children's Services, Central Bedfordshire Council
Dr P Hassan	Chair of Bedfordshire Clinical Commissioning Group
Cllr Mrs C Hegley	Executive Member for Social Care, Health and Housing, Central Bedfordshire Council
Mrs J Ogley	Director of Social Care, Health and Housing, Central Bedfordshire Council
Mr J Rooke	Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Mrs M Scott	Director of Public Health
Mr B Smith	Chairman, Bedfordshire Local Involvement Network
Cllr Mrs P E Turner MBE	Executive Member for Economic Partnerships, Central Bedfordshire Council
Cllr M A G Versallion	Executive Member for Children's Services, Central Bedfordshire Council

please ask for Martha Clampitt

direct line 0300 300 4032

date published 23 January 2013

CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **CENTRAL BEDFORDSHIRE SHADOW HEALTH AND WELLBEING BOARD** held in Council Chamber, Priory House, Monks Walk, Shefford on Thursday, 8 November 2012

PRESENT

Cllr Mrs P E Turner MBE (Chairman)
Dr P Hassan (Vice-Chairman)

Dr J Baxter	Director, Bedfordshire Clinical Commissioning Group
Mrs C Bonser	Bedfordshire Local Involvement Network
Mr R Carr	Chief Executive
Mrs E Grant	Deputy Chief Executive/Director of Children's Services
Mrs C Hegley	Executive Member for Social Care, Health & Housing
Mrs J Ogley	Director of Social Care, Health and Housing
Mrs M Scott	Director of Public Health
Mr B Smith	Chairman Bedfordshire LINk
M A G Versallion	Executive Member for Children's Services

Apologies for Absence: Cllrs Dr F Cox

Members in Attendance: Cllrs A L Dodwell
J G Jamieson
A M Turner,

Officers in Attendance:	Miss H Bell	–	Committee Services Officer
	Mrs P Coker	–	Head of Service, Partnerships - Social Care, Health & Housing
	Dr D Gray	–	Assigned Director of Strategy and System Redesign, Bedfordshire Clinical Commissioning Group
	Mrs J Hainstock	–	Head of Partnership Commissioning, BCCG
	Mrs J Moakes	–	Assistant Director Community Safety & Public Protection
	Mrs A Murray	–	Director of Nursing and Quality
	Mrs C Shohet	–	Assistant Director for Public Health, NHS Bedfordshire

SHWB/12/33 **Joint Health and Wellbeing Strategy (JHWBS)**

The Board considered a report of the Director of Public Health which summarised consultation responses to the Draft Joint Health and Wellbeing Strategy.

The report advised that the Draft Joint Health and Wellbeing Strategy had been well received with comments raised during the consultation on the following issues:-

- Improving the health of looked after children;
- Safeguarding and patient safety;
- Reducing childhood obesity;
- Reducing teenage pregnancy;
- Improving outcomes for frail older people;
- Promoting independence and choice;
- Helping people make healthy lifestyle choices;
- Improving mental health for children and their parents;
- Improving mental health and wellbeing of adults.

A number of additional themes had also emerged from the consultation which were now recommended for inclusion in the strategy set out in paragraph 6 of the report. The Board considered that the strategy should focus on a narrow range of issues to facilitate greater impact in the selected areas; in this context, the strategy should not seek to replicate issues and actions which could not be addressed elsewhere.

The Board noted a letter that was tabled at the meeting from the Chairman of Social Care, Health and Housing Overview and Scrutiny Committee summarising its perspectives.

RESOLVED

That the Joint Health and Wellbeing Strategy be updated incorporating those themes outlined in paragraphs 5 & 6 of the report now submitted where the Board could have greatest impact with the final version being presented to the next meeting of the Central Bedfordshire Shadow Health and Wellbeing Board to be held in January 2013.

SHWB/12/34 **Health of Looked After Children**

The Board was invited to consider a report on the progress made in improving health outcomes for looked after children.

An addendum report had been circulated separately to the agenda on the implementation of the post inspection action plan agreed by the Council's Executive on 21 August 2012. The report set out the following:

- Reflection on the first phase of improvement activity under the post inspection Action Plan;
- Summary of the current position;

The Board noted that the Director of Children's Services was revisiting the actions necessary to deliver the required improvements, to take account of both the findings of the Ofsted Inspection and the new Inspection framework.

RESOLVED

That the action instigated by the Director of Children's Services be noted.

SHWB/12/35 **Frail Older People**

The Board considered a progress report on the outcomes for frail older people. The report outlined the work undertaken, progress since the last report to the Board in January 2012, key actions required to deliver improved outcomes and response to commitments made in the draft Joint Health and Wellbeing Strategy.

RESOLVED

(1) That work undertaken to date in delivering improved outcomes for frail older people be noted.
(2) That the Health and Wellbeing Board commit to increasing the understanding of current investment and performance in services for older people.
(3) That the Joint Strategic Commissioning Group produce a report setting out a specific plan detailing desired outcomes and subsequent target dates for consideration by the Board at its meeting to be held in April 2013.

SHWB/12/36 **Community Beds Review**

Dr Dianne Gray, Assigned Director of Strategy and System Redesign, Bedfordshire Clinical Commissioning Group updated the Board review of Community Beds.

The review would seek to establish existing capacity in Central Bedfordshire and Bedford Borough. This would then be complimented by an analysis of future needs to facilitate appropriate commissioning.

RESOLVED

That the Board receive a report on the outcome of the review of the Community Beds in January 2013.

SHWB/12/37 **Authorisation of Clinical Commissioning Group (CCG)**

The Board considered a report on progress with the authorisation process for the Clinical Commissioning Group.

RESOLVED

That the Clinical Commissioning Group update report be noted.

SHWB/12/38 **Report of Adult Safeguarding Board**

The Board considered the annual report of the Bedford Borough and Central Bedfordshire Adult Safeguarding Board.

The report detailed a number of learning points which had contributed to an action plan for the year, details of which were set out at paragraph 20 in the report now submitted.

RESOLVED

That the Annual report of Bedford Borough and Central Bedfordshire Adult Safeguarding Board be noted.

SHWB/12/39 **Commissioning HealthWatch Central Bedfordshire**

The Board considered a report providing an update on progress to develop and deliver Healthwatch Central Bedfordshire by 1 April 2013. The report included the following:

- Children and young people as part of Healthwatch Central Bedfordshire;
- A Healthwatch pathfinder for Central Bedfordshire led by voluntary and community infrastructure organisation to develop a partnership approach to establishing Healthwatch Central Bedfordshire and builds on existing local resources, knowledge and expertise;
- The procurement strategy for Healthwatch Central Bedfordshire;
- Provision of Independent NHS Complaints Advocacy.

RESOLVED

(1) That plans being put in place for the provision of NHS Complaints Advocacy from April 2013 to March 2014 be noted;

(2) That the approach being taken to the role of children and young people in Healthwatch in response to the mandate given by the Central Bedfordshire Youth Council be noted;

(3) That the progress being made towards establishing Healthwatch Cental Bedfordshire particularly through the first meeting of the Pathfinder held in October 2012 be noted.

SHWB/12/40 **Report from LINk**

The Board considered a report from the Chairman of Central Bedfordshire LINK on current LINK activity and findings from visits to care/nursing homes in Central Bedfordshire.

RESOLVED

That the update on LINK work and progress to date, be noted.

SHWB/12/41 **Board Development and Work Plan**

The Board considered a report from the Chief Executive, Central Bedfordshire Council that set out a suggested work programme for 2012 – 2013 for the Board.

The Board noted the following items to be included in the work programme:

- Community Beds review - January 2013;
- Health and Wellbeing Strategy – January 2013;
- Improving outcomes for Frail Older People – March 2013.

RESOLVED

That the work programme for the Shadow Health and Wellbeing Board be approved with the inclusion of

- **Community Beds review – January 2013;**
- **Health and Wellbeing Strategy – January 2013;**
- **Frail and Elderly March 2013.**

SHWB/12/42 **Chairman's Announcements and Communications**

There were no announcements or communications.

SHWB/12/43 **Minutes**

It was agreed that consideration of previous minutes be considered as the first item of business on the agenda.

RESOLVED

That the Minutes of the last meeting held on 6 September 2013 be confirmed as a correct record and signed by the Chairman.

(Note: The meeting commenced at 1.00 p.m. and concluded at 3.00 p.m.)

Chairman……

Date……

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Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Joint Health and Wellbeing Strategy
Meeting Date:	31 January 2013
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Muriel Scott, Director of Public Health

Action Required:

1. To consider and approve the final Joint Health and Wellbeing Strategy 2012-2016

Executive Summary	
1.	This paper presents the final Joint Health and Wellbeing Strategy (JHWS) for Central Bedfordshire. The JHWS aims to improve the health and wellbeing of all but importantly to reduce inequalities by improving the health of the poorest fastest. There are three cross-cutting priorities: • Improved outcomes for the vulnerable • Early intervention and prevention • Improved mental health and wellbeing These are underpinned by nine priority work programmes all of which have indicators to measure progress towards improved health and wellbeing in Central Bedfordshire.

Background	
2.	The Health and Social Care Act places a duty on the local authority and CCGs to develop a joint health and wellbeing strategy for meeting the needs identified in the Joint Strategic Needs Assessment (JSNA).
3.	The priority work programmes are consistent with two of the four emerging themes identified within the JSNA, that: • Investing in early intervention and prevention (for both adults and children) will help increase lifetime opportunities for all, ultimately reducing the need

	for health and social care support in later life • There is no health without mental health, therefore improving mental health and wellbeing remains a high priority The two other themes identified within the JSNA are that: • Improving educational attainment and all-age skills will have a significant impact upon a wide range of outcomes. • There needs to be a continued focus on reducing inequalities by improving the social determinants of health to give residents greater control over their life choices. These will be addressed through other Boards such as the Children's Trust and Central Bedfordshire Together. The HWB will focus on what only it can deliver. It should also be noted that the Troubled Family Programme crosses all four themes within the JSNA and provides an important opportunity to improve health and wellbeing and reduce inequalities.
4.	The nine priority work programmes have been previously considered by the Shadow Health and Wellbeing Board (HWB), were endorsed at the health and wellbeing stakeholder event in February 2012 and have been subject to a three month consultation. The consultation period ran from 8 August to 29 October 2012. The report following the consultation was presented to the Health and Wellbeing Board on 8 November 2012.

Detailed Recommendation	
5.	The JHWS covers the period 2012-2016 and has identified nine priority work programmes where the Board can make the greatest impact. However improving outcomes will require action from a range of organisations and driven through other strategies and plans, these are outlined within the JHWS, as requested during the consultation process.
6.	The Board will ensure that the outcomes from the strategy will make a real difference to the health and wellbeing for the residents of Central Bedfordshire. In broad terms, implementation of the strategy will deliver: • Improvements in health of looked-after children • Improved safeguarding and patient safety • Reduced childhood obesity • Reduced teenage pregnancy • Improved outcomes for frail older people • Increased independence and choice • More people making healthier lifestyle choices • Improved mental health for children and their parents • Improved mental health and wellbeing for adults

	There are measures and targets associated with each of these priorities which will be used to assess progress within Central Bedfordshire. The Board also has a duty to reduce inequalities and therefore where possible, progress will be reported using inequalities measures.
7.	The Governance arrangements for delivering the strategy have been finalised and reporting has been built into the forward plan of the Health and Wellbeing Board. This will ensure that progress against each priority is reviewed regularly and on a rolling programme. The Board will be assured that a delivery plan is in place for each priority, with measurable targets and milestones. This will need to include an analysis of current spend and outcomes. Public Health resource has been identified to help support officers in this work. It is also proposed that an annual report on progress of the JHWS is presented to the HWB in summer 2014, providing an opportunity to review priorities in light of the JSNA re-fresh.
8.	The strategy has been informed by stakeholders and patient voice. It is therefore important that they are kept informed regarding the progress, through groups such as the delivery partnerships and other existing communication channels.

Issues	
Strategy Implications	
9.	The JHWS will require organisations to make investment and commissioning decisions which can best deliver the priorities. Improvements which require additional investment will need to be delivered through the reallocation of existing resources. To inform the reallocation of resources, a clear understanding is needed of the current spend across all the priorities within Central Bedfordshire and all partners will need to sign up to this approach. Resources will need to be allocated proportionate to need or areas where the greatest improvement is required. This may take the form of. either direct service provision or commissioned services as universal or untargeted service delivery is unlikely to deliver the reductions in inequalities required. It may be that some existing services or commissions will need to be reconfigured.
10.	The Board members will want to hold each other to account for delivery, many of the priorities require a partnership approach, for example to deliver integrated care, and this can present challenges as well as opportunities. If progress is slower than desired, members will ensure barriers are unblocked and progress is made and to provide constructive challenge as required.
11.	National Guidance suggests that the JHWS could potentially consider how

	commissioning of services related to wider health determinants such as housing, education or the built environment can be more closely integrated with commissioning of health and social care services. The Board will want to discuss how the JHWS can best influence commissioning through a more place based approach, for example, by examining spend across agencies within each priority.
12.	Bedfordshire Clinical Commissioning Group has taken account of the JHWS when developing its commissioning intentions. The Board may wish to ensure that the commissioning intentions for Central Bedfordshire reflect the priorities within the JHWS, although the requirement for the HWB to agree BCCG commissioning intentions starts once it assumes its statutory powers in April 2013.

Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Financial settlements for partners may directly impact upon the delivery of the JHWS	Medium	Medium	Commissioning arrangements and efficiency programmes will seek to ensure the best outcomes for health and wellbeing. Decisions about investment and disinvestment will be based on evidence of effectiveness and impact
The JHWS does not influence the commissioning decisions of all partners	Low	Medium	The BCCG commissioning intentions make explicit reference to the JHWS. A communication plan to ensure that partners are aware of the final strategy is being developed and capacity has been identified within the Public Health Team to deliver this.

Source Documents	**Location (including url where possible)**
Joint Strategic Needs Assessment	Central Bedfordshire Council's website http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/joint-strategic-needs-assessment-jsna.aspx

Presented by Muriel Scott

Central Bedfordshire

NHS

Bedfordshire Clinical Commissioning Group

Central Bedfordshire Health and Wellbeing Strategy 2012-2016

January 2013

Foreword

This strategy outlines our vision for improving health and wellbeing and reducing health inequalities in Central Bedfordshire. Through working together in partnership we believe that we can make a real difference to the lives of local people.

Whilst the health and wellbeing of Central Bedfordshire's residents is generally good, we are determined to make it better and importantly to ensure that everyone has the opportunity for improved health and wellbeing.

The responsibility to improve health and wellbeing rests with the health and wellbeing board but does not sit with the public sector alone. Our health and wellbeing is determined by the conditions in which we live such as our housing, employment, education and the environment, as well as by the services provided by the public sector. We will therefore be working closely with our partners in the community and voluntary sector, employers, and retailers and of course local communities themselves.

We have recently looked in some depth at the health and wellbeing needs in the area (captured in the Joint Strategic Needs Assessment http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/joint-strategic-needs-assessment-jsna.aspx) which has been used to identify the priorities contained within this strategy. In the current economic climate we need to be sure that we are making the biggest difference to health and wellbeing with the available resources, hence the priorities identified for particular focus initially.

To ensure that we can see the difference we are making to people's lives, we have also identified how we will assure and measure progress.

Cllr Tricia Turner,
Chair of Central Bedfordshire Health and Wellbeing Board

Dr Paul Hassan
Vice Chair of Central Bedfordshire Health and Wellbeing Board and Chief Clinical Officer, Bedfordshire Clinical Commissioning Group

Health and Wellbeing in Central Bedfordshire

Central Bedfordshire, a predominantly rural location was, in 2011, home to about 254,400 residents, an increase of 20,700 (8.9%) since 2001. Central Bedfordshire has a growing and ageing population which is expected to increase to 274,400 by 2016. The biggest increase of around 87% (between 2010 and 2031) will be in the number of people aged 65 and over, which has implications for future health and social care needs.

The population of Central Bedfordshire is growing due to increasing life expectancy, a rising birth rate and inward migration.

Average life expectancy at birth in Central Bedfordshire is increasing and is currently 79.5 years for men and 83.0 years for women. These are similar to East of England and better than the England averages. Life expectancy is increasing at the rate of about 2.5 years for men and 1.5 years for women every decade.

Geographically there is a range of life expectancy within Central Bedfordshire: the gap between the most affluent and most deprived areas is on average 5.5 years for women and 7.4 years for men. Also, some disadvantaged groups have lower life expectancy. People in the more deprived areas die earlier predominantly due to diseases of the circulatory system, cancers, especially lung cancer; diseases of the respiratory system and diseases of the digestive system.

There are a number of common themes which emerged from the recent re-fresh of the Joint Strategic Needs Assessment:

- Investing in early intervention and prevention (at all ages) will help increase lifetime opportunities for all, ultimately reducing the need for health and social care support in later life, particularly for frail older people
- There is no health without mental health, therefore improving mental health and wellbeing remains a high priority
- Improving educational attainment and all-age skills will have a significant impact upon health and wellbeing
- There needs to be a continued focus on reducing inequalities by improving the social determinants of health such as housing, employment and the built environment, to give residents greater control over their life choices.

These themes have been used to inform the priorities within the strategy. The responsibility for improving educational attainment rests with schools and is a priority within the Children's and Young People's Plan overseen by the Children's Trust. Action to address educational attainment has therefore not been included within this strategy.

The responsibility for improving the social determinants of health rests predominantly with Central Bedfordshire Council in conjunction with its partners. Whilst improving the social determinants of health is not currently a priority work programme within the HWBS, it remains a high priority locally with action being delivered through strategies such as all-age skills strategy, transport strategy, leisure strategy and the strategic housing strategy. These and other relevant plans are shown on pages 16 and 17.

Vision

What will health and wellbeing look like for the residents of Central Bedfordshire?

Our vision is to ensure that Central Bedfordshire is:

A place where everyone can enjoy a healthy, safe and fulfilling life and is recognised for its outstanding and sustainable quality of life

We will do this by working in partnership with our communities and residents to improve the opportunities open to them to improve their health and wellbeing

Our Priorities

Informed by the JSNA we have identified three cross cutting priorities where we want to make progress fastest:

- Improved outcomes for those who are vulnerable
- Early intervention and prevention
- Improved mental health and wellbeing

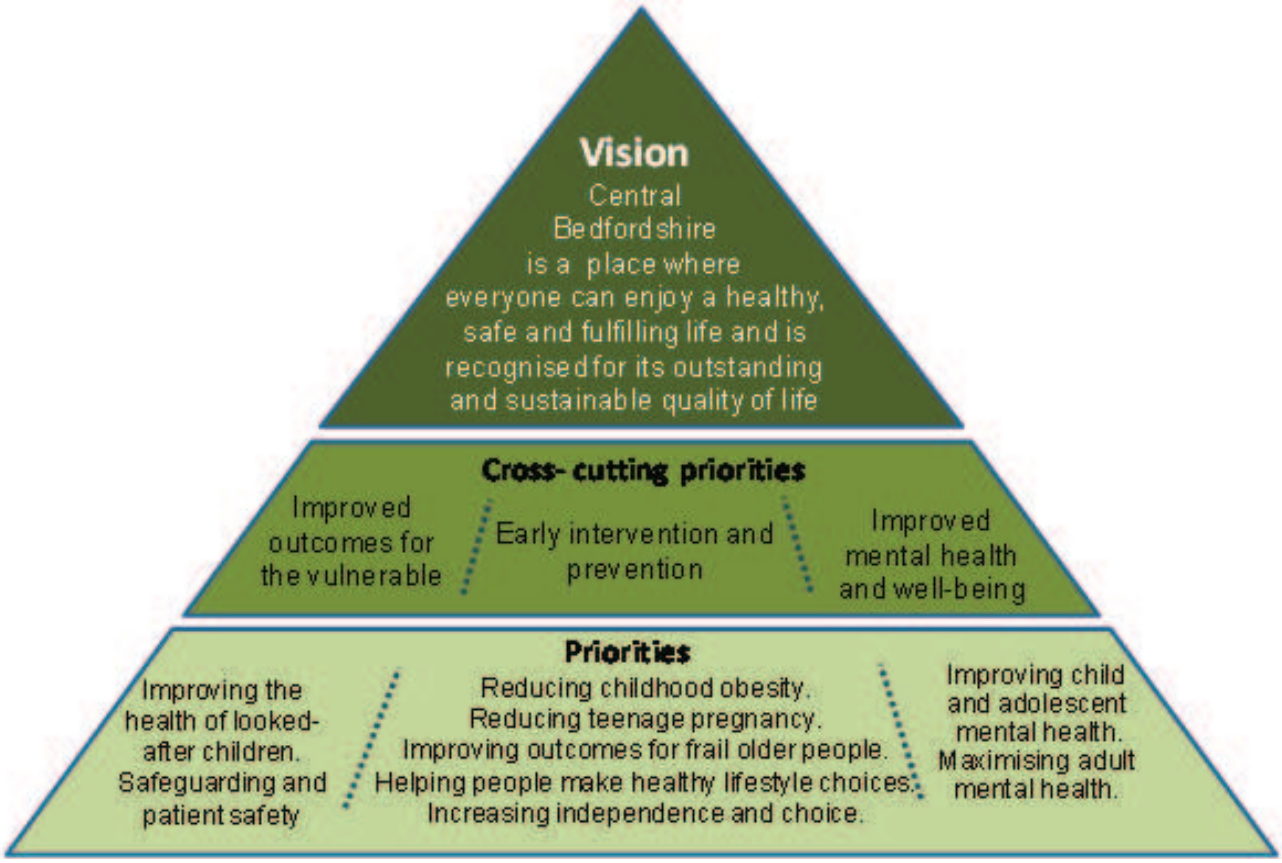
These are underpinned by nine priority work programmes all of which have indicators to measure our progress. These priorities will be reviewed annually to ensure that they remain the right priorities to deliver improved health and wellbeing in Central Bedfordshire.

Reducing health inequalities is a key theme running through each and every priority of the strategy. Progress in reducing health inequalities will be monitored by the Health and Wellbeing Board and will be made in the areas of greatest need.

The relationship between the vision, priorities and how we will measure the difference we make is illustrated in figure 1.

The constituent members of the Health and Wellbeing Board have a responsibility to hold each other account for delivery, ensure that the interventions proposed are effective and are configured to deliver the best possible outcomes. We know that improved outcomes will be achieved through using current resources together and more effectively.

Figure 1: Health and Wellbeing: The vision, priorities and Indicators



The rationale for choosing each priority, what we will do to improve outcomes and how we will measure our progress is set out in the following part of the strategy.

Cross Cutting Priority: Improved outcomes for the vulnerable

Priority 1: Improving the health of looked after children

Why it's important

Looked After Children (LAC) are amongst the most vulnerable groups in society and they are at an increased risk of poor outcomes during the early years of life onwards. LAC and young people share many of the same health risks and problems as their peers, but often to a greater degree. They may enter care with a poorer level of health than their peers in part due to the impact of poverty, abuse and neglect.
Numbers of looked after children in Central Bedfordshire have increased by 45% over the last 3 years and health outcomes for looked after children in Central Bedfordshire are poor compared to the East of England and England averages. A recent Ofsted/CQC Inspection reported that health services for looked after children in Central Bedfordshireare inadequate and outlined a number of specific areas to be addressed.

What we will do

- Redesign LAC health services to meet the needs of LAC and care leavers in Central Bedfordshire, shaped by clinicians, partners, LAC and care leavers
- Ensure all looked after children have prompt access to appropriate services which promote good outcomes for them, including their emotional health and well-being
- Ensure that all looked after children and young people have access to age appropriate health education and promotion information
- Work with the Eastern Region on a peer support and challenge programme to ensure sustainable improvement
- Ensure that there is a smooth transition into adult services to ensure that the continuing health needs of young people leaving care are met

How we will measure our progress

- Increased percentage of LAC who received their initial and review health assessment within the statutory time frames
- Increased percentage of LAC whose immunisations are up to date and whose teeth have been checked
- Improved scores from the Strengths and Difficulties Questionnaire (SDQ) used during review assessments of LAC
- Improved LAC and young people's evaluations of the health services they receive which demonstrate that services are improving and meeting their needs

Priority 2: Safeguarding and Quality of Care

Why it's important

Safety is fundamental to the wellbeing and independence of people using health and social care. As more people are enabled to live more independently with support in the community, it is important to guard against the potential for abuse and neglect and to ensure sustained high quality services. Abuse in any form can impact on a person's physical and mental health, finances and social interactions. People are more likely to become unwell, socially isolated or may find it difficult to make important decisions in their lives due to stress or coercion.
Ensuring that people receive high quality care, are treated with dignity and respect and have their care needs met is essential to achieving good outcomes and is one of the highest priorities for the public and professionals alike.

What we will do

- Protect people when they are unable to protect themselves, including advocacy services that are available for people who are unable to challenge or change circumstances that they experience
- Ensure people have access to information and advice about protecting themselves, the services they use and what to do if they are being harmed or abused
- Ensure that in commissioning services, providers of care have excellent systems in place to ensure the safety of adults whose circumstances make them vulnerable to abuse
- Ensure robust systems and policies are in place and are followed consistently; to provide training and supervision, to enable staff to recognise and report incidents of adult abuse, to provide expert advice and to reduce the risks to vulnerable adults
- Increased public awareness of safeguarding and improved systems for reporting of possible abuse
- Ensuring the accommodation needs of vulnerable adults and children are met
- We will follow the national 'Working Together' guidance on how we, as strategic partner and other agencies should work together to safeguard and protect children

How we will measure our progress

- More people who use services who say that those services have made them feel safe and secure
- Reduced incidence of newly-acquired category 3 and 4 pressure ulcers
- Reduced incidence of healthcare associated infection – MRSA (Meticillin-Resistant Staphylococcus Aureus) and C difficile
- Improved patient experience of hospital care
- Assess the quality of discharge arrangements measured by an increased proportion of older people (65 and older) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Cross Cutting Priority: Early intervention and prevention

Intervening early and as soon as possible to tackle emerging problems for children, young people and their families is critical if health and wellbeing is to be maximised. It is never too early and never too late to take a preventative approach; hence this theme crosses all age groups. There are however some areas where an increased focus on early intervention and prevention is required.

Priority 3: Reducing childhood obesity

Why it's important

Currently 1 in 5 children in the most deprived areas are obese by the time they reach the age of 11. In the rest of Central Bedfordshire 1 in 7 children are obese by the age of 11.
Conditions linked with obesity in childhood include low self esteem, depression and musculo-skeletal problems. As overweight and obese children are more likely to go on to become obese adults, they are then at increased risk of type 2 diabetes, cardiovascular disease, respiratory conditions, and certain cancers. There is an exponential rise in risk as the level of obesity increases.
Preventing and reducing obesity in childhood will increase healthy life expectancy and reduce health inequalities.

What we will do

- Provide family based treatment programmes for managing childhood obesity targeted in the areas where obesity levels are highest (BeeZee Bodies and BeeZee Tots)
- Support schools to provide high quality physical activity and healthy eating through programmes such as Making the Most of Me and Change 4 Life
- Support pregnant women who are overweight or obese to introduce healthy living choices and reduce weight gain in pregnancy
- Support women to initiate and continue to breastfeed successfully
- Ensure that the leisure strategy and active travel plan deliver increased opportunities for children and their families to be more physically active by promoting affordable activities such as those within the natural environment

How we will measure our progress

- Reduced levels of Obesity in children in reception (age 4-5) and year 6 (age 10-11)
- Reduced inequalities in levels of obesity between the 20% most deprived areas and the rest of Central Bedfordshire
- Increased number of lower schools delivering 'Making the Most of Me', an obesity and self-esteem programme
- Increased numbers of children and their families enrolled in programmes to reduce levels of obesity such as BeeZee Tots and BeeZee Bodies.
- Increased breastfeeding in initiation
- Increased 6 -8 week breastfeeding rate

Priority 4: Reducing teenage pregnancy

Why it's important

While individual young people can be competent parents, all the evidence shows that children born to teenagers are much more likely to experience a range of negative outcomes in later life.The majority of teenage parents and their children live in deprived areas and often exhibit multiple risk factors for poverty, experiencing poor health, social and economic outcomes and inter-generational patterns of deprivation. The links between teenage pregnancy, deprivation and poverty are inextricable with each of the teenage pregnancy hotspot wards falling within the 20% most deprived in the Central Bedfordshire area.

What we will do

- Support young people to make positive choices about their relationships and their sexual health by increasing access to high quality sexual health services and unbiased and accurate information, whilst helping young people to stay safe and recognise abusive or coercive relationships
- Deliver specialist work with young people who may be at an increased risk of teenage pregnancy, in their schools and within their local communities to help build resilience to the pressures of modern adolescence
- Deliver the 'Aspire' programme which aims to build the resilience of children who may be disengaging from education by working on raising their self esteem and aspirations. This approach helps the more vulnerable children realise and increase their potential
- Ensure that teenage parents are well supported access a range of individually tailored support in the antenatal period through to birth and beyond, to enable the best possible outcomes for themselves and their children
- Help to reduce subsequent unintended pregnancies by increasing access to contraception and sexual health services after birth and post termination

How we will measure our progress

- Reduced under 18 conception rate
- Increased numbers of young people under 20 accessing local sexual health services
- Increased numbers of mothers under 20 accessing contraception after birth of their baby to reduce subsequent pregnancies
- Increased numbers of vulnerable young and at risk young people in receipt of targeted relationships and sexual health interventions
- Increased numbers of early intervention 'Aspire' programmes delivered in Middle and Upper Schools in high rate ward areas

Priority 5: Improving outcomes for frail older people

Why it's important

Frailty is associated with a loss of independence and vulnerability which impairs the quality of life and psychological well-being of many older people. This in turn is likely to result in increased need for health and social care support.
There are an estimated 6,500 frail older people in Central Bedfordshire currently but this is expected to double within the next 20 years.
Whilst there is some excellent local service provision, at times it can be disjointed, responding to rather than preventing crisis, with too many people losing their independence.
Improving outcomes for frail older people will allow those residents to maintain or regain their independence whilst ensuring that they do not become socially isolated.

What we will do

- Promote health by increasing the uptake of established screening and prevention programmes
- Commission an expansion of the multi-disciplinary complex care team to deliver a case management service to reduce reliance on hospital admission
- Commission alternative models of day services, increase the number of intensive home care packages and use of personal budgets, and improve access to telecare and telehealth
- Commission comprehensive information, support and advocacy and brokerage services
- Commission improved and integrated dementia services and improve access to psychological services for older people
- Ensure that additional Village Care schemes are commissioned
- Ensure suitable accommodation options are available by improving housing and accommodation support and existing extra care housing options
- Ensure effective floating support services; provide affordable warmthand the provision of signposting and information

How we will measure our progress

- Decreased emergency admissions for acute conditions that should not usually require hospital admission
- Reduced permanent admissions to residential and nursing care homes
- An increased proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- An increased proportion of people who use services who say that those services have made them feel safe and secure
- Reduced delayed transfers of care from hospital, and those which are attributable to adult social care
- An increased proportion of people who use services and carers who find it easy to find information and are satisfied with their care and support

Priority 6: Promoting independence and choice

Why it's important

Supporting people to live independent lives and encouraging greater choice and control is fundamental. It is important that vulnerable people should have greater choice of personalised services which promote and sustain independent living.
Securing high quality care for all in a climate of economic downturn and changing demography requires a fundamental shift in how care is provided. Early loss of independence often leads to increased social care spend e.g. residential care represents £29 million or 34% of net spend on adult social care in Central Bedfordshire. Equally, early use of residential care depletes the resources of those who fund their own care, consequently leading to greater demands for publicly funded support. Loss of independence can also mean increased use of acute care.

What we will do

- Shift the balance of care from institutional to personal solutions with more effective support for people in their own homes, including widening the use of Telecare, extra care and specialist equipment to promote independence
- Ensure that people are able to access information and support to help them manage their care needs enabling them to regain and retain their independence
- Ensure people are able to manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. Work with Community and Voluntary organisations to enhance the support available locally to people and their carers
- Continue to support timely discharge from hospital and adopt a whole systems approach to delivering rehabilitation and reablement to promote independence
- Ensure that Carers receive the care and support they need to enable them to continue in their caring role as well as maintaining their own health and wellbeing

How we will measure our progress

- More people with a long term condition feeling they have had enough support from local services to help manage their condition
- An increased proportion of people who use services and carers who find it easy to find information about support
- An increased proportion of people using social care who receive self-directed support and those receiving direct payment
- An increased proportion of people with learning disabilities living in their own home or with their family and an increased proportion in paid employment

Priority 7: Helping people make healthy lifestyle choices

Why it's important

Adopting healthy lifestyles can prevent or delay ill health. On average a person who adopts a healthy lifestyle (doesn't smoke, eats 5 portions of fruit & vegetables a day, drinks moderate amounts of alcohol and is physically active) will live 14 years longer than a person who adopts none of these behaviours.
17.5% of adults in Central Bedfordshire smoke, however this increases to 22.4% in the most deprived areas. Within Central Bedfordshire 14.4% of new born babies are living in a home with at least one smoker. Impacting on smoking prevalence demands attention on the wider tobacco control agenda and not just stop smoking services.
Only 11% of adults in Central Bedfordshire are physically active enough to benefit their health.
It is estimated that 49,000 adults (25%) are obese of whom it is estimated 9,000 have high blood pressure, 4,000 have cardiovascular disease and 3,000 have diabetes as a direct result of their weight.
In 2009/10 there were over 4,000 admissions to hospital as a result of alcohol related harm, an increase of 13% from the previous year. Heavy drinking is not restricted to the young; 20% of adults aged 65 years and over are estimated to be heavy drinkers.

What we will do

- Ensure that our built environment and leisure services support people to be as physically active as possible
- Support people to reduce their drinking to safe levels through community based support
- Support people with substance misuse difficulties by ensuring timely access to effective substance misuse services
- Support people to stop smoking at a time and location convenient to them
- Address tobacco control though the Bedfordshire Tobacco Free Alliance
- Provide 12 weeks free access, via General Practitioners, to accredited commercial slimming groups for people who wish to reduce their weight
- Make Every Contact Count so that when our staff are in contact with people who wish to change their lifestyle that they are signposted to sources of help
- Offer an NHS Health check 5- yearly to every person aged between 40-74 years who has not already been identified as at high risk of vascular disease such as heart or kidney disease. This will allow early identification and treatment which prevents or delays the consequence of disease

How we will measure our progress

- Reduced smoking prevalence and increased smoking quitters
- Reduced percentage of adults who are obese
- Reduced rates of alcohol related admissions to hospital
- Increased take up of NHS Health Checks by those who are eligible
- Increased % leaving drug treatment free of drugs of dependence

Cross Cutting Priority: Improved mental health and well-being

Priority 8: Improving mental health for children and their parents

Why it's important

There is no health without mental health; this is the key message of the National Mental Health Strategy. In Central Bedfordshire, one in ten children aged between 5 and 16 years has a mental health issue or illness, this is over 3,500 children. Self-harm in young people is not uncommon with 10-13% of 15-16 year olds having self harmed. The evidence shows that half of those with lifetime mental health problems first experience symptoms by the age of 14, which is why early intervention is so critical to reduce the burden of poor mental health and help children and young people to build resilience into adulthood.
One in ten new mothers experience postnatal depression which is why recognition of the initial stages of the illness by health professionals, and adequate support is so crucial to reduce the negative impacts upon both the parents and their children.

What we will do

- Further develop and integrate early intervention services to ensure prompt and timely support for children and young people with emerging mental health problems
- We will review the service model for new mothers experiencing post natal depression
- We will enhance local specialist services for young people with eating disorders
- Ensure that a preventative and early intervention approach is taken with a focus on parenting support programmes
- Ensure that those young people with ongoing mental health problems have a smooth transition to adult mental health services
- Ensure Child and Adolescent Mental Health (CAMH) services for children with Learning Disability are integrated across health and social care
- Redesign CAMH services for Looked After Children to ensure early intervention
- Involve stakeholders and service users in the review of the integrated mental health and local authority services for children with a learning disability, against the service specification
- Commission programmes in targeted schools to raise self esteem and build resilience among children and young people at an increased risk of poor mental health

How we will measure our progress

- Increased the number of children and young people from Central Bedfordshire seen by the newly commissioned early intervention CAMH service (CHUMS)
- Improved average Strengths and Difficulties (SDQ) scores for children and young people receiving an intervention from CHUMS

Priority 9: Improving mental health and wellbeing of adults

Why it's important

Mental well-being has been a frequently ignored aspect of health and well-being; however it underpins and interacts with wider physical and social aspects of health and well-being. Mental health problems are common and have a significant impact upon health: one in six of the adult population experiences mental health problems at any one time and a quarter of the population will experience a mental health problem at some point in their lives.

Mental health problems are estimated to be the commonest cause of premature death and years of life lived with a disability. Poor mental health is associated with a variety of health damaging behaviours, including smoking, drug and alcohol misuse, unwanted pregnancy and poor diet.

People can benefit from work not only financially, but also in their general wellbeing. There is strong evidence that programmes to encourage and support people with mental health problems into work offer high economic and social returns.

Dementia can affect all in society irrespective of gender, ethnicity and class and can have a devastating impact on those affected and their family carers. Dementia can affect adults of working age as well as older adults although people with learning disabilities are a group at particular risk.

What we will do

- Improve mental health through wellbeing and prevention services
- Reduce waiting times for assessment and treatment
- Maintain people's mental health post-treatment through better primary and community care services
- Increase access to talking therapies
- Improve the way care is delivered to people with dementia, and for their carers including improved access to memory clinics for people with dementia
- Continue to support people to improve and keep their mental health, through programmes such as Change 4 Life and Making Every Contact Count
- Improve each patients experience through mental health services
- Ensure that more people with mental health issues are appropriately treated within GP practices/primary Care

How we will measure our progress

- Increased proportion of people with mental illness will report improved experience of healthcare within specialist secondary care
- Increased access to talking therapies
- Increased percentage of people with mental illness in settled accommodation and in paid employment
- Reduction in the suicide rate

How we will report on progress and delivery

All the partners of the Health and Wellbeing Board have agreed the shared vision and priorities set out in this strategy. They are committed to working together and providing integrated care to our residents and patients as far as possible.

The Children's Trust and the Healthier Communities and Older People's Partnership Board have the responsibility for overseeing the delivery of the priorities. Action plans are either already in place or are being developed. Delivery against these action plans and importantly the associated indicators will be reported to the board on a six monthly basis.

The indicators which will be used to measure progress are detailed in appendix A

Priority	Partnership responsible for delivery	Lead Directors and Lead Agency
Improving the health of looked after children	Children's Trust	Director of Quality and Safety (BCCG) and Director of Children's Services (CBC)
Safeguarding and Patient Safety	Safeguarding Adults Board	Director of Adult Social Care Health and Housing (CBC) and Director of Quality and Safety (BCCG)
Reducing childhood obesity	Children's Trust	Director of Public Health (CBC)
Reducing Teenage Pregnancy	Children's Trust	Director of Public Health and Director of Children's Services (CBC)
Improving outcomes for frail older people	Healthier Communities and Older People's Partnership	Director of Adult Social Care Health and Housing (CBC)
Promoting independence and choice	Healthier Communities and Older People's Partnership	Director of Adult Social Care, Health and Housing (CBC)
Helping people make healthy lifestyle choices	Healthier Communities and Older People's Partnership	Director of Public Health (CBC)
Improving mental health for children and their parents	Children's Trust	Director of Strategy and Redesign (BCCG) and Director of Children's Services (CBC)
Improving mental health and wellbeing of adults	Healthier Communities and Older People's Partnership	Director of Strategy and Redesign (BCCG)

Key:
BCCG - Bedfordshire Clinical Commissioning Group
CBC - Central Bedfordshire Council

Additional Local Strategies and Plans that support the delivery of the Health and Wellbeing Strategy

Improving outcomes in line with the priority areas requires action from a range of organisations, driven through other strategies and plans. These strategies are identified below:

*- currently being developed/ refreshed

Priority	Key strategies and plans
Improving the health of looked after children	• Children and Young Peoples Plan 2011- 2014 * • Ofsted Action Plan
Safeguarding and patient safety	• Bedfordshire Domestic Abuse Strategy and Action Plan * • Bedfordshire Sexual Abuse Action Plan
Reducing childhood obesity	• Central Bedfordshire Obesity Strategy • Central Bedfordshire Leisure Strategy • Environmental Enhancement Strategy • Children and Young Peoples Plan 2011-2014
Reducing teenage pregnancy	• Think Family Parenting Strategy • From Poverty to Prosperity: A strategy to reduce child poverty and alleviate its effects in Central Bedfordshire • Children and Young Peoples Plan 2011- 2014* • Bedfordshire Sexual Health Strategy*
Improving outcomes for frail older people	• The Central Bedfordshire Carers Strategy 2011-2014 • Improving Outcomes for Older People in Central Bedfordshire2011 – 2014
Promoting independence and choice	• Improving Outcomes for Older People in Central Bedfordshire 2011 – 2014 • Mental Health Strategy Delivery Plan 2011-2014 • The Central Bedfordshire Carers Strategy 2011-2014 • All Age Skills Strategy
Helping people make healthy lifestyle choices	• Bedfordshire Sexual Health Strategy * • Central Bedfordshire Obesity Strategy • Central Bedfordshire Leisure Strategy * • Environmental Enhancement Strategy • Tobacco Control Action Plan • Bedfordshire Alcohol Strategy 2012-2015

Improving mental health for children and their parents	• Think Family Parenting Strategy • Environmental Enhancement Strategy • Mental Health Strategy Delivery Plan 2011-2014 • Bedfordshire Domestic Abuse Strategy and Action Plan * • Bedfordshire Sexual Abuse Action Plan • All Age Skills Strategy
Improving mental health and wellbeing of adults	• Central Bedfordshire Leisure Strategy * • Environmental Enhancement Strategy • Think Family Parenting Strategy • Improving Outcomes for Older People in Central Bedfordshire 2011 – 2014 • Mental Health Strategy Delivery Plan 2011-2014 • The Central Bedfordshire Carers Strategy 2011-2014 • Bedfordshire Domestic Abuse Strategy and Action Plan * • Bedfordshire Sexual Abuse Action Plan

Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Bedfordshire Clinical Commissioning Group Commissioning Intentions 2013-14
Meeting Date:	31 January 2013
Responsible Officer(s)	John Rooke, Dr Paul Hassan
Presented by:	Dr Diane Gray, Director of Strategy & System Redesign, BCCG

Action Required:

1. To note the engagement of partners in the development of these commissioning intentions
2. To note the commissioning intentions and their impact on the Board's strategic priorities
3. To advise on how the Board wishes to be more fully engaged in development of the 2014-15 commissioning intentions

Executive Summary	
1.	Bedfordshire Clinical Commissioning Group (BCCG)'s commissioning intentions document (attached) sets out the ambitions and priorities for BCCG in the next financial year. Its intended audience is broad, and includes current and potential providers of NHS-funded care, patients and the public, and partner agencies.

Background	
2.	The commissioning intentions document is one of a suite of products (which also include an annually refreshed strategy and an annual whole system integrated plan) which will be routinely produced by BCCG. It is informed by BCCG's strategy document, and will in turn inform the whole system integrated plan. Since BCCG's underpinning strategy is informed by the Joint Strategic Needs Assessment, these commissioning intentions directly relate to the Health & Wellbeing Board's strategic priorities, and set out how BCCG plans to play its part in addressing them.

3.	Final budgets have yet to be formally agreed by the NHS Commissioning Board for Bedfordshire Clinical Commissioning Group, but, given the planning guidance that emerged just before Christmas, our financial position in 2013-14 will be challenging. Our estimate is of a £23million pressure on an overall budget of circa £460million, i.e. a 5% challenge. This is by far the greatest financial challenge felt on the local NHS economy in recent years, and will require an unwavering focus on driving greater efficiency and value out of local care, whilst ensuring quality remains high and safety remains paramount.
Detailed Recommendation	
4.	In a normal year, the production of BCCG's commissioning intentions would have included greater involvement by the Health & Wellbeing Board. However, the timetable of transition, including the establishment and authorisation of Bedfordshire Clinical Commissioning Group, has meant a more accelerated process has had to be undertaken this year. Despite that, these commissioning intentions have been published three months later than planned (in January 2013 rather than Sept-October 2012). Despite being an accelerated process, the development of the 2013-14 commissioning intentions involved a series of six workshops, including one specifically for patients, one for providers, one for programme boards, and two for the CCG Executive and local authority invitees. Therefore, we are confident that these commissioning intentions are a fair reflection of what our partners and patients are expecting of us.
5.	The headline commissioning intentions by local authority are set out in Appendix 2. The table below links them to the priorities of the Health & Wellbeing Strategy:

H&WB priority	BCCG commissioning intention
Reducing teenage pregnancy	Review of community gynaecology care (including services for the termination of pregnancy)
Reducing childhood obesity	Work with public health to increase the public recognition of obesity and related health issues.
Improving mental health for children and their parents	Review of paediatric urgent care pathway (including review of provision of care for children with long term conditions). Work with Central Bedfordshire Council to develop integrated systems and processes outlined in the Special Educational Needs and Disability green paper.

	Improving the health of looked after children	Improve health service provision and outcomes by implementing a new service model and reviewing its effects after 6 months.
	Prevention and early intervention for adults and older people	Review and gap analysis of current falls-related projects with subsequent action plan to respond to gaps and best practice
	Improve outcomes for frail older people	Develop a local plan with Central Bedfordshire Council commissioners that will commission a model of integrated health and social care from providers working in partnership. This will include: • Recommissioning the local community beds configuration as a result of the community beds review • Commissioning increased consultant geriatric support to primary care and community based teams • Continuing to review and improve Continuing Health Care processes and arrangements
	Improve mental health & wellbeing	Review community mental health teams to ensure that mental health support is appropriate, accessible, and responsive and recovery focussed. Commission a comprehensive primary care mental health model that promotes wellbeing and ensures that people are assessed and treated at the earliest point in their illness. Increase support to early assessment and diagnosis for dementia
	Safeguarding and patient safety	Review the transition from children to adult services and in particular the use of the Multi-Agency Transition Tool (MATT)
	Promoting independence and choice for adults and older people	Use findings of national review of stroke care – in conjunction with Healthier Together programme of clinical service change – to commission services that increase independence following stroke. Ensure adequate support for carers of people with dementia.

	Further details of these plans are set out in the full commissioning intentions document. The Integrated Plan – to be published in Quarter 4 2013 – will provide further information on the outcome measures and indicators that will be used to monitor progress.
6.	The planning for commissioning intentions in 2014-15 will start early in the new financial year. This time, BCCG would wish to more fully engage the Health & Wellbeing Board and constituent partners and would wish to bring an early iteration to the Board in May and/or July, prior to Board sign-off in September.

Issues	
Strategy Implications	
7.	This paper links to the Health & Wellbeing Board Strategy as set out in paragraph 5 above
8.	This paper directly relates to the BCCG 2012-15 commissioning strategy
Governance & Delivery	
9.	The development of these commissioning plans will be overseen by BCCG
Management Responsibility	
10.	As chief clinical and operational officers for BCCG, Dr Paul Hassan and John Rooke are the Board's leads for delivery against these commissioning intentions.
Public Sector Equality Duty (PSED)	
11.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty No
	No Yes *Please describe in risk analysis*

Risk Analysis
Briefly analyse the major risks associated with the proposal and explain how these risks will be managed. This information may be presented in the following table.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Financial settlement worse than expected	2	5	Commissioning plans assume a worst-case financial position.
Partnership arrangements slower to develop than necessary	1	3	Joint Commissioning Group in place with work plan and accountability to Board
Capacity to lead reviews and redesigns is limited	3	3	Prioritisation of review/redesign projects to ensure capacity is deployed as effectively as possible

Source Documents	**Location (including url where possible)**
BCCG (Draft) Commissioning Intentions 2013-14	

Presented by Dr Diane Gray

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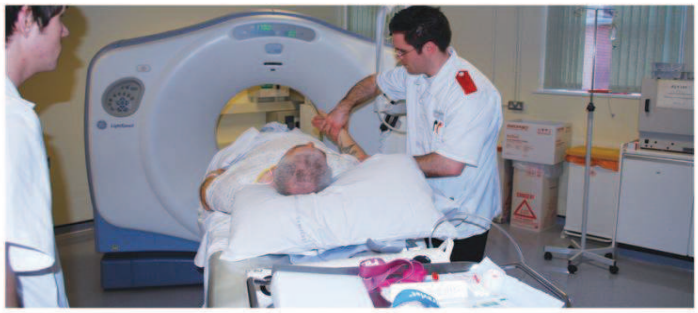
NHS

Bedfordshire Clinical Commissioning Group

Draft

Commissioning Intentions

2013-14



better care, better value, better health

Contents

BACKGROUND AND CONTEXT

1. Bedfordshire and its people

Bedfordshire CCG (BCCG) population is split between the two unitary authorities Bedford Borough and Central Bedfordshire. BCCG is composed of 5 localities: Bedford, Chiltern Vale, Leighton Buzzard, Ivel Valley and West Mid Bedfordshire (See Figure 1). Bedford locality is almost co-terminous with Bedford Borough Council with which it shares the same health issues of a largely urban population. The remaining localities form the area covered by Central Bedfordshire. Chiltern Vale covers the towns of Dunstable and Houghton Regis, both of which contain significant pockets of deprivation. Leighton Buzzard locality, although one of the smallest, covers a town with an active town council and strong community engagement. Ivel Valley and West Mid Bedfordshire cover largely rural areas with generally good overall population health.

Population Demographics, Health Need, and Clinical Quality	
	• BCCG serves a total population of 437,650 (2011/12), set to rise by approximately 12% by 2021. • Numbers of people above 65 years are expected to grow at a faster rate, rising by approximately 30% by 2021. • The gap of around ten years between life-expectancy for those best off in Bedford Borough and those worst off (11.3 years for men; 9.1 years for women), is widening, with life expectancy decreasing in the most deprived parts. • Life expectancy for those best-off in Central Bedfordshire is significantly greater (by 7.4 years for men and 5.5 years for women) than for those worst off. • People from minority ethnic groups (BME) constitute 19.2% of the Bedford Borough population and 13% in Central Bedfordshire, compared to 17% in England. Particularly large BME communities reside within in Queens Park (57.8% in 2001) and Cauldwell (43.6%) wards • Causes of death: Circulatory disease 31%, Cancer 28%,Respiratory disease 9% (2010)

(Bedfordshire Borough Council And Central Bedfordshire Joint Strategic Needs Assessment)

Figure 1. BCCG 5 Localities

The Bedford Borough Council Health & Wellbeing Strategy sets out eight priority areas, underpinned by five crosscutting principles, and all derived from the Borough's joint strategic needs assessment. The eight priority areas are:

Teenage pregnancy	Health and educational outcomes in looked after children
Mental wellbeing (children and adults)	Tobacco control (children and adults)
Healthy weight (children and adults)	Safeguarding (children and adults)
Independence in older people	End of life care

Equity **Accessibility** **Integration** **Effectiveness** **Sustainability**

The key priorities agreed by the Central Bedfordshire Council Health & Wellbeing Board are:

For children:	For adults and older people:
Reducing teenage pregnancy	Prevention and early intervention
Reducing childhood obesity	Improve outcomes for frail older people
Improving mental health for children and their parents	Improving mental health and wellbeing
Improving the health of looked after children	Safeguarding and patient safety
	Promoting independence and choice

2. Context for 2013/14 Planning

During 2012 Bedfordshire Clinical Commissioning Group set out its vision *"to ensure, through innovative, responsive and effective clinical commissioning, that our population has access to the highest quality health care providing the best patient experience possible within available resources"*. With that in mind, these commissioning intentions set out our priorities for 2013/14, building on the national strategy for health care, as described in the Health and Social Care Act (2012). Further refinements to our commissioning intentions will come as the impact of the NHS Commissioning Board Planning Guidance for 2013/14 and CCG financial are fully explored and the final decisions on the local 'Healthier Together' (acute services review) programme are made. This will form our Integrated Plan for 2013/14 which will be finalised in March 2013.

Our Strategic Commissioning Plan sets out the framework for commissioning decisions for the next 3 years, based on information about current needs, demands and national and local context. Our starting point is the health needs of the people of Bedfordshire. With the knowledge of our clinicians and the experience and support of our patients, we will build on what works well and change what needs to work better. We will do this by:

- WORKING IN PARTNERSHIP with our member practices and localities, with patients, carers, HealthWatch and the public, with local councils, and with other healthcare providers

- USING CLINICAL LEADERS to challenge and champion, and to develop new ways of providing care in general practice

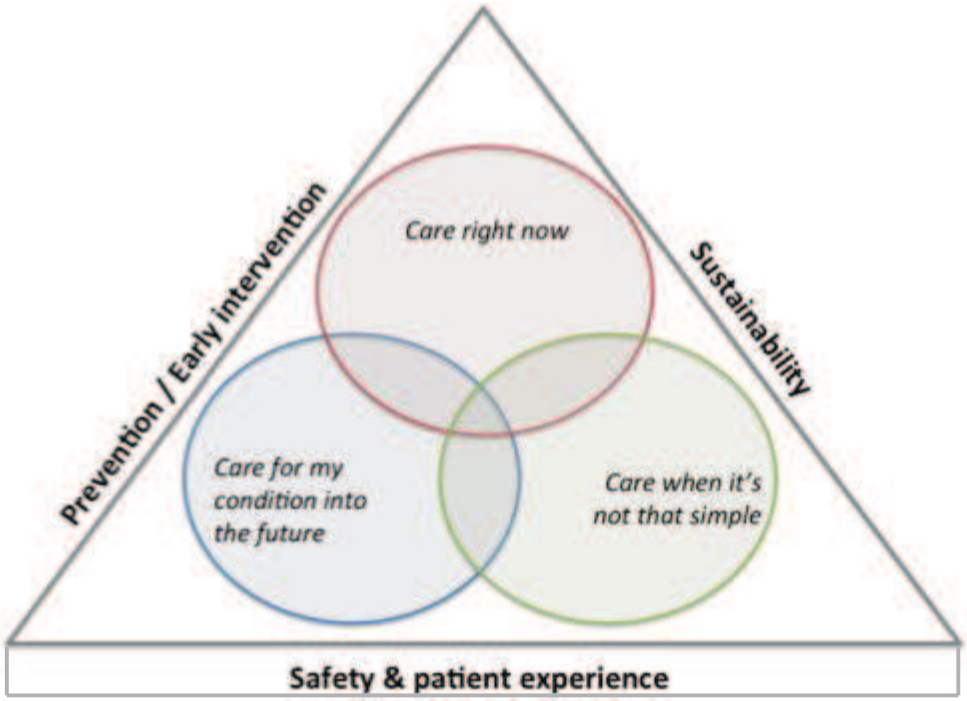
- FOCUSING ON OUTCOMES, by using our purchasing power to improve co-ordination of patient care

By working in this way, using clinicians and patients to drive change and focusing on a key set of outcome-based priorities, we believe we can both produce improvements in quality and efficiency and provide financial and reputational 'head room' to invest in future priority areas. Our approach will be underpinned by a core set of values:

VALUES	
	TRUST We will do what we say we will do so that patients and other stakeholders have confidence in us to commission healthcare services for our patients. DECISIVENESS We will make our commissioning decisions at an appropriate pace, ensure our systems remain fit for purpose and are aligned to delivering values. DELIVERY We will achieve the goals and objectives that we set for ourselves, ensure our systems remain fit for purpose and are aligned to delivering our values. INCLUSION We will commission healthcare services in a fair, equitable and transparent way to meet the needs of the population in Bedfordshire. ACCOUNTABILITY AND PERFORMANCE We are accountable for commissioning healthcare services for our local population and we will do this within a framework of effectiveness, efficiency and transparency, remaining within our resource limits.

The proposed strategic approach to commissioning better value healthcare for Bedfordshire residents breaks down the totality of the healthcare we must commission into three key areas of focus with three cross-cutting themes, each of which have associated priority outcome indicators (taking into account the NHS Outcomes Framework and local Health & Wellbeing priorities) that we aim to achieve. The three key areas of focus with their crosscutting themes are set out in the figure below.

Figure 2: Proposed key areas of focus and themes



The three key areas are:

Care right now: urgent or unscheduled care

The existing system can be confusing and duplicative, resulting in a less than optimal patient experience and inefficient use of resources. Patients who need medical advice, diagnosis and/or treatment quickly should be able to have a consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need from a joined up system of care, irrespective of the day of the week or time of the day that the need arises. We will review how patients' access 'care right now' and the co-ordination of that care back to their general practice so that any necessary follow-up can be undertaken promptly.

Indicator:

We will improve patients' experience of urgent care services, including walk-in centres, GP out of hours services and A&E services, so that more than 85% patients rate their overall experience as good or very good by 2015.

Care for my condition into the future: planned care and long term conditions

As the Bedfordshire population ages, long term conditions (conditions that cannot be cured but can be managed through medication and/or therapy) are becoming more prevalent. Evidence points to best value care in long term conditions being provided through empowering and supporting patients such that they are informed and ready to self-manage. In Bedfordshire, through system redesign and in conjunction with the outputs of the 'Healthier Together' programme, we will develop prepared,

proactive community-based teams that can work in partnership with patients to improve outcomes. This means fewer outpatient appointments, more happening in GP surgeries and community settings, and specialist skills being used appropriately.

Indicator:

We will increase the proportion of people with a long term condition who feel they have had enough support from local services to help manage their condition from 66% (in 2011) to 80% by 2015.

Care when it's just not that simple: addressing complex care needs

Once people need on-going assistance with their care and/or activities of daily living because of physical or mental impairment or both, it becomes more important than ever for healthcare and social care services to work together in partnership. In Bedfordshire, we will work with Bedford Borough Council and Central Bedfordshire Council to bring together the planning, payment and provision of health and social care into integrated systems of care for those with complex needs. Through system redesign, we will create primary care-based multidisciplinary teams that interface with urgent care services in order to support carers and maintain patients' independence for as long as is safely possible and ensure a good quality of life.

Indicator:

We will work with social care to increase to at least 85% the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

Cross-cutting themes

The cross-cutting themes of prevention, sustainability and safety and customer care will underpin all activities of the CCG.

Prevention and early intervention: making every contact count

The Wanless reports from last decade demonstrated how greater measures were needed to prevent illness and slow down deterioration if healthcare is to remain affordable. NHS-funded care must play its part by 'making every contact count', ensuring staff take the opportunity to recommend healthy lifestyles to patients and embrace that advice in their own lives. This starts in childhood, and we are committed to continuing the supportive approach adopted by health visitors and the Family Nurse Partnerships. We will work in conjunction with partners, especially the unitary authorities and the NHS Health Checks programme, and see our role as reinforcing public health messages, leading by example and ensuring that those that need extra support are identified and directed towards suitable care.

Sustainability: financial, environmental, social

The CCG has a role as a corporate citizen, committing to promote sustainability of environmental and fiscal resources internally through its actions as a corporate body and externally by the way in which it commissions. Efforts to ensure sustainability can be integrated with improving outcomes for patients, improving productivity, and ensuring financial balance.

Safety and patient experience

Our patients expect care to be provided safely and we will work to the regional ambitions of eliminating avoidable pressure ulcers, having zero tolerance for healthcare-acquired infections and 'never' events, and working to prevent falls at home and in hospital. But more than that, patients should expect to be treated courteously and with respect and dignity, with services fitting around them rather than vice versa.

Financial Context

At the time of writing these commissioning intentions the Planning Guidance for 2013/14 and CCG allocations have just been published alongside the Road Test Tariff for 2013/14.

The full impact of the new tariffs and the planning guidance has yet to be fully worked through in terms of financial impact, however a number of uncertainties have been clarified as follows:

- the indicative baseline CCG allocation for 2013/14 is £429.5m increasing from £419.8m from 2012/13 after including the nationally announced uplift for CCGs of 2.3%
- the running cost allowance of £25 per head is allocated separately to the baseline allocation above and for Bedfordshire CCG is £10.73m
- the CCG will plan to set aside 2% of income and spent non-recurrently following approval of plans from the Commissioning Board Local Area Team
- the CCG will plan to make a cumulative surplus of 1% during 2013/14, this will be carried forward to 2014/15
- the national tariff deflator is a net 1.3% reduction assuming inflation of 2.7% and provider efficiency requirement of 4.0%
- the level of Commissioning for Quality and Innovation payments (CQUIN: the proportion of healthcare provider that depends on achieving agreed improvement and innovation goals) will remain at a minimum of 2.5%
- the CCG will plan to budget for all non elective admissions at 100% tariff and the NHS Commissioning Board will administer the 70% balance for local investment in relevant demand management schemes in partnership with the CCG.
- the CCG will hold a minimum 0.5% contingency to mitigate local health economy risk, this is in addition to the 2% set aside for non-recurrent investment mention above.

In addition to the plan requirements set out above, the CCG plans to set aside funding to ensure that it starts the year in recurrent balance by funding known baseline financial pressures such as continuing care and also set aside funding to support local provider transformation.

At this point some uncertainties still exist and will become clearer over the next few months as the CCG finalises its contracts and develops its service and financial plans for next year and beyond. These include:

- the actual and anticipated level of demographic led activity growth
- any significant structural changes to the final published tariff
- the impact of business rules for reablement, social care transfers to LA

Our latest assumptions suggest that we will have a gap between recurrent income and recurrent expenditure of c £25.4m in 2013/14, comprising the following:

	Latest Assumptions	
	£m	%
Baseline allocation 2012/13	**419,818**	
Income:		
Resource Uplift	(9,656)	-2.30%
Tariff Deflator	(3,640)	-1.30%
Expenditure:		
Demographic/Activity – Change & Growth	11,293	2.69%
CQUIN change	0	2.50%
1% CCG Surplus Requirement	4,198	1.00%
2% Transformation Reserve	8,396	2.00%
Fund pressure on Continuing Health Care	6,000	1.43%
Contingency Reserve	2,099	0.50%
Provider Transition support	5,000	1.19%
30% Marginal Rate adj held by NHSCB	1,700	0.40%
Savings Requirement	**25,391**	**6.05%**

Clinical Commissioning

The Health and Social Care Act (2012) makes Clinical Commissioning Groups (CCGs) responsible for commissioning services they consider appropriate to meet local health needs. By April 2013 all Primary Care Trusts will be abolished. The differences between how we approach commissioning are:

- BCCG is rooted in our communities through Health and Wellbeing boards, GP membership and patient and public engagement.
- GPs are providing active clinical leadership for commissioning, working with providers to make key decisions over resource utilization at a population level.
- BCCG is changing the nature of negotiations with health care providers from discussion ton numbers of procedures and visits to patient outcomes and value.
- BCCG is leading meaningful engagement with patients and the public to understand what outcomes matter, what currently works well and what needs to change to improve the quality of their experience and the outcomes of their care.

The relevant context in which BCCG adopts this approach is:

- The current economic situation: there is no real term increase in health care funding. The potential for real term decreases in funding from next Comprehensive Spending Review means we must ensure providers offer value for money services that focus on improving patient outcomes.

- Due to changing commissioning responsibilities there is a greater need to work collaboratively with the NHS Commissioning Board and Local authorities to commission better outcomes for complete pathways of care.
- Policies such as 'Any Qualified Provider' encourage competition and the introduction of new healthcare providers. Alongside service reconfiguration local hospitals will face increasing challenges to ensure excellence in quality service provision and value for money.

IMPLEMENTING OUR STRATEGY IN 2013/14

3. Developing our plans

BCCG's commissioning changes are developed and implemented at locality level and through five programme boards: urgent care; planned care; mental health; prescribing; and children and maternity (this latter one in development). Each board includes clinicians and patients in its membership and has a CCG clinician as Senior Responsible Owner (SRO), who is supported by a programme manager and a team of project managers. During September-October 2012, planning workshops have been held with programme boards and localities, with Local Authority and with patients and health care providers, where themes and proposals for commissioning changes have been developed.

These proposals are considered within the context of priority-setting. It is increasingly accepted that priority setting in publicly-funded health care systems is inevitable. As demand for health care has increased – driven by an ageing population, advances in medicine and higher patient expectations – the need to establish procedures for allocating scarce resources has become more pressing. Developments in the field of priority setting have become especially urgent in the current context of economic austerity, in which the welfare system of England is subject to greater financial constraint.

To facilitate robust decision making that ensures our population has access to the highest quality health care providing the best patient experience possible within available resources, BCCG has developed a prioritisation process that supports commissioners in determining or refining our priorities. The agreed criteria are based upon BCCG's Ethical and Commissioning Principles.

The criteria are shown below:

Criteria	Assessment
Strategic Fit	How does the proposal demonstrate that as a minimum there is a major contribution to the BCCG Strategy and one or more key national targets?
Governance (Legal & Clinical)	Is there a legal requirement for the CCG to undertake this proposal or is this covered by NICE Technology Appraisal Guidelines?
Assessed Needs	Has population need been assessed through a health needs assessment?
Evidence Based	Is the proposal clearly supported by robust evidence of effectiveness?
Effect on Inequalities	Is the proposal proven to reduce inequalities?
Access	Does the proposal include a health equity audit to assess access? What is the impact on access e.g. reduced waiting times, increased choice or convenience, earlier identification of risk or diagnosis, closer to home care
Financial Impact	Is there any cost or saving implications to the proposal?
Value for Money	Is the proposal proven to be cost effective for the outcomes it will achieve?
Achievability	Does the proposal have a clear plan with realistic timescales and assumptions? Has evaluation been planned?
Acceptability	Is there strong evidence of supporting patients and stakeholders in the service design? Is there support from patients and the public?
Magnitude of health gain	Who will benefit and how? E.g. what is the impact on life expectancy/mortality, quality of life/health status, healthy behaviour change, patient experience, quality of care etc.
People who will benefit	How many people within our population will the proposal benefit?
Risks of not implementing	What is the impact if this proposal is not prioritised?

The scope of BCCG commissioning programmes and interventions included for consideration this year are taken from the following areas:

- Locality Plans
- Urgent , Integrated Care and End of Life Care
- Planned Care, Long Term Conditions and Cancer Care
- Mental Health and Learning Disabilities
- Children's and Maternity Care
- Medicines Management

4. Stakeholder Engagement

To facilitate meaningful stakeholder engagement, ten merging themes were taken from the planning workshops and developed into patient stories that depicted how the patient experience is today, and how, by making changes to the ways care is delivered, patient experiences may differ next year. These emerging themes were then shared, discussed and debated at deliberative engagement events with patients, public, carers and service users and the local health and social care provider organisations.

The 10 areas are only part of the suite of health care changes being considered as priority areas/identified as developments that will commence next year. The deliberative events highlighted

four top priorities as expressed by represented patients, public and carers and provider organizations. These will have been highlighted as important areas within our prioritisation process:

- Care Coordination (Health & Social Care Coordinator; a trained member of staff that supports individuals, families and carers to navigate and coordinate the range of health and social care services available to them)
- Developing the primary health care multi-disciplinary team
- Integrated Care
- Dementia Care

The outcomes of the deliberative events are summarised in appendix 1.

Next Steps to continue engagement

This document provides an opportunity to continue the dialogue we have started with patients, the public, and providers. It is being published openly within the public domain and promoted through local channels, in order to encourage further comment and discussion on shaping our proposals as they are refined and implemented.

Clinical Leadership

CLINICAL LEADERS will challenge and champion, and develop new ways of providing care in general practice:

- We will use clinical leaders to challenge existing institutional boundaries, bringing primary care closer to patients' homes, specialist care out of hospital buildings and into the community, and both primary and specialist care into closer working relationship with each other
- We will encourage clinicians to champion examples of high value healthcare and practice, promoting and supporting take-up across the localities
- We will develop and support the CCG's constituent practices to be able to take on a significantly different model of care in the future – one that sees more care co-ordinated through the practice, greater provision of care closer to and in patients' homes, and increased collaboration with other providers, including voluntary sector and social care. This may require reconsideration by practices of, for example, their space utilisation, staff skill mix, and use of technology.
- We will increasingly make all clinicians more accountable for quality, financial probity, and incident reporting.
- We will involve clinicians in the capture of soft intelligence from their patients on the experiences of healthcare, good and bad.

Patients and the public

We will WORK IN PARTNERSHIP with patients, carers and the public to build on what works well and change what needs to work better.

- We will embrace the experience of the public, patients and carers to tell us how services are now, advise us on how they could be better, and help us evaluate the impact of the commissioning decisions we make on the quality of care delivered in the future.

- We will work with local LINKs and then Healthwatch and other patient representative organisations to develop new ways of engaging and informing people, especially those who sometimes struggle to be heard.

Public consultation

We will work with our Local Authorities and scrutiny committees to identify substantial developments to health services and then coordinate formal public consultation process to gather feedback from the public, local authority, third sector, clinicians and other service providers.

Local Authority partners

We will work in partnership with our local authority colleagues to promote greater integration of planning, payment and provision between the NHS and social care. Joint commissioning strategies are in place for the following client groups:

Bedford Borough Council:

- Dementia
- Mental Health
- Older people

Central Bedfordshire Council:

- Dementia
- Mental Health
- Older people

Through Health & Wellbeing Boards and their respective joint commissioning groups, we will identify and act on priority areas for greater joint working between local commissioners. BCCG Commissioning Intentions are summarised by Local Authority in Appendix 2.

Service providers

We will plan with neighbouring health economies the commissioning of care from sensible and higher value configurations of specialist services through the 'Healthier Together' programme, which aims to improve the quality, safety and affordability of health services provided across the South East Midlands area.

The significant service reconfiguration ambitions of this programme for acute hospitals will take time to deliver. Alongside supporting the changes required of 'Healthier Together' we will need to work with our acute providers to develop new contracting and payment methods that ensure resources follow patients, i.e. where care is provided closer to home, specialist staff, equipment and finances are

available to do this. This will require both greater use of local tariffs and a move away from traditional activity-based contracts towards contracts and specifications focused on systems of care (e.g. musculoskeletal care, care for frail older people) and that reward improved outcomes for patients.

The Health & Social Care Programme Board and the BCCG QIPP leadership board provides an opportunity to bring together senior representatives from across the health and social care local system – commissioners and health care providers – to monitor, challenge and hold to account the implementation of these changes. This assures that the impact to the entire local health system and the impact of change on patient pathways is clearly understood and articulated. Integration will be a key agenda; reviewing the development of Integrated Services between hospital and community e.g. Diabetes Services and ensuring that these specialist services also integrate with other relevant services e.g. Cardiology.

COMMISSIONING INTENTIONS

5. *Care right now*: urgent or unscheduled care

In order to deliver the outcome of:

We will improve patients' experience of urgent care services, including walk-in centres, GP out of hours services and A&E services, so that more than 85% patients rate their overall experience as good or very good by 2015.

We have been working on a variety of service reviews and changes throughout 2012 which will contribute to improving patient experiences of services for urgent care.

Achievements over the last year

- *Minor illness Care pathway*

A new GP service in close proximity to Bedford Hospital Trust is working with the hospital to provide services for patients with a minor illness. This means if patients present to A&E with a minor illness that could be better treated by primary care services, they are redirected to the practice to receive the appropriate clinical care.

- *Urgent Care Services and older people who fall*

When an older person falls over and a paramedic crew assesses them as medically fit, a social worker then visits and assesses their home situation to ensure the patient's ongoing safety. This service is jointly provided by the East of England Ambulance Service and social care from Bedford Borough and Central Bedfordshire councils.

We will be taking further steps towards improving patient experiences of urgent care services.

Priorities and Challenges for 2013/14

- *Falls Prevention*

Integrated Health & Social Care Falls Prevention Management Service – a full review of all falls-related projects will be undertaken and clear plan of action to respond to gaps and best practice to be developed in conjunction with both Local Authorities and Public Health.

- *Out of Hours Dressings*

Review of the delivery of out of hours dressing's services and commission services to meet the needs of localities. Consider the removal of the term 'housebound' as it is seen as a block to getting good patient care in the community and is becoming less meaningful as more care moves into home settings in general.

- *Review of walk-in centre services*

We will look holistically at the model of walk-in urgent care, including our expectations of Accident & Emergency departments and the part played by other access points such as walk-in centres and general practice. In doing so, we will actively seek patient and public feedback through engagement and consultation.

- *Out of Hours GP services*

We will review these services in order to:

- Examine the impact of opening hours of OOH on A&E visits.
- Examine the impact of out of hours GP services being able to perform basic diagnostics e.g. ECG and blood tests, on A&E demand.
- Explore the options for out of hours service provision where there are opportunities to improve patient experience

- *Maternity Tariffs*

We will undertake a shadow exercise in preparation for new forms of maternity tariffs in 2013/14 to look at financial implications for local acute trust maternity services. Examine in detail differences in admission rates for local maternity units and develop plans to address any inconsistencies in line with best practice.

- *Paediatric urgent care services*

Prompted by higher than expected emergency admissions for long term conditions in children and young people and changing evidence of best practice in paediatric urgent care, we will look at the patterns of urgent care received by our children and young people and work in conjunction with the Healthier Together programme to commission an up to date model of care.

Notice of Changes and Planned Service Reviews

- **Review all falls-related projects in conjunction with Public Health and Local Authorities**
- **Review of the delivery of out of hours dressing's services and commission services to meet the needs of localities**
- **Review of walk-in centre services**
- **Review of scope of out of hours GP services**
- **Review Of Maternity Services Liaison Committee (MSLC) arrangements to ensure arrangements are effective**
- **Review of the Paediatric urgent care pathway**

6. *Care for my Condition into the Future:* planned care and long term conditions

In order to deliver the outcome of:

We will increase the proportion of people with a long term condition who feel they have had enough support from local services to help manage their condition from 66% (in 2011) to 80% by 2015

We have been working on a variety of service reviews and changes throughout 2012 in order to increase the proportion of people who feel they have had enough support to manage their condition.

Achievements over the last year

- *Reducing Variation*

The variation between GPs when making referrals into secondary care has been under significant review and a number of initiatives to support GPs in decision making implemented. The launch of benchmarked, standardized information, peer review of referrals, clinical education and training programmes , a referral information web site (GPRef), the development of GP checklists for procedures of lower clinical value, and the implementation of Practice Development Managers roles within localities have supported GPs to ensure referral pathways are evidenced-based and clinically appropriate, with optimum high quality care being provided within a primary care setting. This has resulted in improvements in the quality of care provided within primary care and an overall reduction in the numbers of referrals being made by GPs to specialist services.

- *Best Practice approach to outpatient follow up appointments*

Acute hospital contracts have been performance managed against national best practice Follow Up ratios, ensuring that hospital follow up visits are clinically appropriate.

- *High Cost Drug Validation*

The prescription of high cost drugs within hospital settings has been regularly reviewed to ensure evidence-based prescribing

- *New Diabetes & COPD Services*

Integrated Services that span primary care and secondary care settings, providing care and support delivered closer to home, instead of having to attend hospital appointments. Led by clinicians, the innovative services are provided by staff at both Bedford Hospital and Luton and Dunstable Hospital but in a variety of community facilities. A review of the services will be completed by December 2012.

- *Dementia*

This initiative involves working in partnership with Local Authority Colleagues to implement the National Dementia Strategy. It focuses upon early diagnosis and intervention, increased quality of care in general hospitals, living well in dementia care homes and a reduction in the use of antipsychotic drugs. Achievements include:

- More appropriate anti-psychotic prescribing by working with pharmacies, care homes and GPs locally.

- A new Improving Access to Psychological Therapies Service for children is being delivered by 'CHUMS': child bereavement, trauma and Emotional Wellbeing service.
- "Singing for the Brain" service is in place and operating across Central Bedfordshire and Bedford Borough.
- Two additional Dementia support workers have been appointed by the Alzheimers Society and are providing increased support and information to carers and their cared for.

- *Eating Disorders*

The development of an Integrated Eating Disorder Pathway encompasses a smooth transition from children's and young people's services into adult services and reduces the requirement for out of area care.

- *Mental Health*

We are working in partnership with Local Authority colleagues to implement a Mental Health and Wellbeing Integrated Stepped Care Model aimed at improving the transition of care from children's and young people's services into adult services and the interface between services. This includes:

- A new model to deliver care close to home to support people with mental health conditions to stay well.
- Four link workers are now in place in Primary Care settings

- *Autism*

An evidence-based multi-agency diagnostic pathway for Autistic Spectrum Disorders for children and young people across Bedfordshire and Luton has been designed and will be implemented in early 2013. A review of the impact of the new pathway is planned for autumn 2013. Work focusing on adults with Autism has included:

- The development of a Local Strategy
- An education program which has resulted in over 350 people having training in understanding Autism
- A review of the model for social skills development provided by Autism Bedfordshire has led to increased opportunities for support.

- *Learning Disabilities*

A Health facilitation Service is in place and supporting more people with learning disabilities to access Primary Care services.

Medicines Management

- Improved use of antibiotics in line with local guidelines. This has been associated with a reduction in *Clostridium difficile* infections to less than half the rate from 2009-10.
- Improved adherence to local blood glucose monitoring guidelines, reducing unnecessary testing for patients
- Generic medicines provide better value for the NHS and overall have more data to support patient safety. 200,000 more prescriptions were written and dispensed as generically available medicines in Bedfordshire than in the previous year.

- 10,000 fewer prescriptions dispensed for non-steroidal anti-inflammatory drugs (NSAIDs) associated with a higher risk of cardiovascular events.
- Through an award winning dietetic service (Food First) commissioned by the Medicines Management Team we have improved use of regular food for patients rather than issuing cartons of liquid feed to frail patients. This has resulted in improvements in weight for patients and their quality of life. BCCG now uses 77% fewer cartons than the England average.
- Improved access to dressings for district nurses so that they can use dressings without the need to obtain a prescription.
- Improved access for patients with coeliac disease to gluten free foods. Patients can now obtain these directly from community pharmacies without the need for a prescription.

We will be taking further steps towards increasing the proportion of people who feel they can manage their condition.

Priorities and Challenges for 2013/14

- *Musculoskeletal Services*

Based upon recommendations within the National Musculoskeletal (MSK) Service Framework, a clinical network has developed clinical recommendations on a new proposed system of care across elective orthopedic, rheumatology, podiatry, chronic pain and physiotherapy care. GPs across all five localities of the BCCG and patient representatives are continuing to develop a clinical system specification.

A procurement process will result in the BCCG commissioning an integrated MSK system through an outcome based incentivized prime contract. This prime contract and system approach will incentivize clinicians and providers to use their expertise to design and lead integrated services based around the patient, delivering seamless, coordinated care across the MSK system. The new integrated MSK system will improve the patient experience, delivering the best possible outcomes to patients within the resources available, whilst bringing care closer to home using hospital facilities only when necessary.

- *Cardiology*

A System redesign project is underway which will deliver a revised model of care focusing on prevention and providing more care with Consultants and specialist staff supporting services in community-based settings, closer to home and reducing the need to visit hospital.

- *Ophthalmology*

A system redesign project is underway which will deliver greater community provision and closer working amongst primary care practitioners. A joint commissioning model with local authority partnership is being adopted and this initiative is part of a national UK Vision project which is working with only three CCGs within the UK to implement the national Vision Strategy.

- *Dermatology*

A series of engagement events and steering group work, including patient representatives, hospital and community clinicians, local GPs, public health and commissioning staff have developed a new integrated model of care that will shift a significant proportion of dermatology services out of hospital into closer to

home in community based settings. A procurement process will commence in 2012 and result in a new model of delivery aimed at improving patient experience, patient determined population health & wellbeing outcomes, increased quality, improved value for money and a reduction in health inequalities.

- *Gynaecology*

Initially steered by a local pilot to provide consultant led gynaecology outpatient appointments in a community, this project will be evaluated to determine if a CCG wide model of care will provide high quality care, closer to home, improving patient experience and value for money.

- *Neurological disorders*

Opportunities are being explored to develop a multidisciplinary approach to the treatment and management of pre and post neurological disorders. Up until now, these have been considered individually as separate neurological conditions, including Epilepsy, Chronic Fatigue syndrome (CFS/ME), Multiple Sclerosis (MS) and Acquired Brain Injury (ABI).

- *Stroke*

A national review of the whole Stroke pathway is underway, existing national performance indicators demonstrate there is a need to significantly improve aspects of service provision and will locally form part of the 'Healthier Together' programme for clinical service change. The findings of this review will be considered in terms of local need and commissioning requirements for increasing independence following stroke.

- *Cancer Pathways*

Cancer specific service specifications are being developed to support future pathway commissioning. These will include expectation for full implementation of enhanced recovery pathways, reduction in cancer follow up where clinically appropriate and delivery of care closer to home.

- *Community Mental Health Teams*

We will explore a model of care where Community teams operate seven days a week and provide a service to all ages (from 18 years old) There will be a specialist CMHT that will deliver services to people suffering with an organic disorder e.g. Dementia.
There will be increased support for people with physical conditions that impact on their mental wellbeing.

- *Primary Care Mental Health Services*

Primary care mental health services will deliver an increased range of interventions and support. There will be an increase in the availability of psychological therapies and this will be equally accessible for hard to reach groups. There will be increased support for people with physical conditions that impact on their mental wellbeing.

- *Dementia*

Increase the support to early assessment and diagnosis for dementia to ensure the best possible outcomes for treatment. To ensure people with dementia maintain their independence as long as possible and that there is adequate support in place for carers.

- *Multi-Agency Transition Tool*

To ensure smooth transition from children to Adult services an audit of current transition pathways will be undertaken with the purpose of testing the effectiveness and implementation of the Multi Agency Transition Tool (MATT), which will be used across all agencies.

- *Looked After Children*

To improve health service provision and outcomes for Looked After Children through implementation of the new service model in March 2013, with a service review planned for September 2013.

- *Children with Long Term Conditions*

To work with local acute and community providers to develop local pathways to support a effective treatment for children and young people with long term conditions, in particular Asthma, Epilepsy and Diabetes.

- *Medicines Management*

The focus for medicines management in 2013/14 will change to include 'Helping patients to get the best from their medicines' (medicines optimisation). This will be achieved through greater engagement with patients and by working more effectively across health and social care settings.

We know that:

- Provision of medicines is the most frequent healthcare intervention within the NHS.
- Between 5% and 17% of unplanned hospital admissions in the UK are due to medication issues.
- Most long term conditions are managed using medicines and yet full adherence to these medications is only about 60%.
- Across England £300m is wasted each year on unused medicines (half of which is avoidable), however at least £500m a year is wasted through not getting the expected benefits of medicines due to patients not taking medicines properly.

The work plan for 2013-14 will consist of a number of individual projects which will have commonality and overlap within an overall medicines optimisation plan. Projects which will be underway by 1st April 2013 include:

1. A new programme to improve communication of medicines between acute trusts, community in-patient units, GP practices and community pharmacies so as to ensure that information is accurate and timely and that community pharmacy skills are utilized more fully, in particular NHS Medicines Usage Reviews (MURs) and the New Medicines Service (NMS).
2. A new programme across health and social care to improve medicines support given to patients with dementia and their carers.

3. As part of our expansion of support for care homes we will implement a project working with care homes staff to support improved use of inhalers and eye preparations within care homes
4. Development and accreditation of Healthy Living Pharmacies (HLPs) promoting self-care and improved access and choice of care through our community pharmacy network.
5. Development of a range of resources available for patients and carers to support improved adherence with prescribed medication for long term conditions such as diabetes and asthma.
6. A follow up to our 2011 medicines waste campaign to further reduce the amount of medicines wasted each year in Bedfordshire

In addition, we will continue to optimize value and safety through appropriate prescribing of medication including:

1. Increase the proportion of prescribing as generic medication where clinically appropriate.
2. Use of human insulin in preference to analogue insulin for patients with type 2 diabetes mellitus.
3. Reduce the use of high dose inhaled corticosteroids in asthma and COPD where clinically appropriate.
4. Reduce the amount of benzodiazepines prescribed for more than 28 days
5. Further reduce the amount of prescribing of non-steroidal anti-inflammatory drugs (NSAIDs) associated with higher cardiovascular risk.
6. Further reduce prescribing of antibiotics for viral or self-limiting infections so that resistance levels are minimized.

The medicines management team within Bedfordshire CCG will lead these projects through both direct support and facilitation. However medicines optimisation isn't a pharmacy-only issue, but will involve collaboration across all health and social care along with patients and public.

Notice of Changes and Planned Service Reviews

- **Review of new Integrated COPD and Diabetes Services**
- **Procurement of new MSK System Model complete and service delivery starts**
- **Procurement of new Dermatology System Model complete and service delivery starts**
- **Commission Community Cardiology Services**
- **Joint Commissioning of Vision services with Local Authorities**
- **Review of Community Gynaecology Pilot**
- **Review and re commission of Neurological Disorders model of care**
- **Implement recommendations of Stroke Pathway Review**
- **Commission Cancer Specific evidence-based pathways**
- **To review community mental health teams to ensure that mental health support is appropriate, accessible, responsive and recovery focused**
- **To develop a comprehensive primary care mental health model that promotes wellbeing and ensures that people are assessed and treated at the earliest point in their illness.**
- **Review of redesigned looked after children service**

7. *Care when it's just not that simple*: addressing complex care needs

In order to achieve the outcome:

We will work with social care to increase to at least 85% the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

We have been working on a variety of service reviews and changes throughout 2012 in order to increase the proportion of people aged 65 and over who are still at home three months after leaving hospital for rehabilitation in the community.

Achievements over the last year

- *Integrated Care*

A joint community beds review is being undertaken by BCCG, Bedford Borough Council and Central Bedfordshire Council, supported by a Public Health led evidence review. Its findings will inform the strategic commissioning of community-based recovery and rehabilitation jointly by BCCG and the local authorities. It will consider the opportunities from combining purchasing power between NHS and local authority commissioners and improving value for money on community-based care. Its findings are due to be released in early 2013.

- *Complex care in community settings*

This initiative is an innovative 12 month pilot where a whole patient pathway has been commissioned for the care of older people presenting or at risk of presenting at Luton and Dunstable NHS Foundation Trust. The pathway includes clinical navigation teams actively seeking out patients who could be cared for in the community setting and arranging their transfer from A&E, assessment units and wards. The team has access to a short stay medical unit in Houghton Regis that is led by a Consultant Geriatrician, and rapid intervention teams and rehabilitation & enablement teams, working together with social workers to track and manage the patient journey.

- *End of life care*

A 12-month pilot called Partnerships for Excellence in Palliative Support (PEPS) delivers a hub and spoke model of end of life care. Providers (including from the third sector) have come together to deliver the service in partnership, and the greater coordination of care has been shown in an interim audit, to have improved the number of people dying in their preferred place of death and reduced lengths of stay in hospital. A 12-month evaluation of the service is due in December 2012.

- *Additional support to care homes*

A multidisciplinary team consisting of Pharmacists and advanced nurse practitioners are working with Bedford locality GPs to deliver case management model within residential and nursing homes. Following a successful pilot, the 3 year service has been commissioned to provide nursing assessments and medication reviews for this vulnerable group. During the pilot phase, commissioners saw a reduction in A&E attendances and non-elective admissions from participating homes.

Priorities and Challenges for 2013/14

- *Integrated Care*

NHS Bedfordshire, practice based commissioning groups and Bedfordshire Clinical Commissioning Group have engaged and supported a number of redesign projects in urgent care in previous years. The collective learning of these initiatives can be summarised as;

1. Small scale projects do not deliver the scale of change now required within healthcare
2. Addressing individual elements of the patient pathway e.g. discharge, do not yield whole system improvement
3. There is interdependency between providers that means greater partnership is required

As a result of the things we have learned from previous years, Bedfordshire CCG has a vision for integrating services for the benefit of local people. We have a lot of work to do to reach this ambition. We need to work in partnership with other commissioners and we need to plan the journey from the fragmented model we currently have, to the joined up provision we wish to see.

Bedfordshire CCG will be working with each Local Authority to develop local plans for addressing challenges. We expect to deliver a shift in care provision away from acute hospitals toward community solutions where it is safe and effective. We will develop commissioning plans for implementing the outcomes and recommendations of the community bed review and aim to deliver more joined up care for the benefit of local people. Where there is joint funding of services, commissioners will come together to jointly manage performance e.g. SEPT community health services.

In order to move the health economy toward this way of planning and providing care, we expect to deliver the following changes in 2013/14. We would also value discussions with providers to see how they can come together to deliver greater partnership working in 2013/14.

- *Developing the 'Primary Care Health Team'*

This includes a community geriatrician to support comprehensive older people's assessment and advice for complex patients enhancing quality of care, enabling older people to receive care where they reside and preventing unnecessary hospital admission.

- *Community Nursing*

This will align community nursing teams to GP practices. This will be with the aim of providing holistic care, maximizing and maintaining independence and working with GPs to provide effective case management of people at risk of hospital admission.

- *Navigation of health and Social Care*

Test the efficacy of a Health and Social Care 'Broker' (Care Coordinator) to help patients/relatives/carers navigate the health and social care system. This was tested in Torbay and was considered to be the single biggest impact role. It should begin to align disparate teams towards an integrated model.

- *Falls Prevention*

Integrated Health & Social Care Falls Prevention Management Service – a full review of all falls-related projects will be undertaken and clear plan of action to respond to gaps and best practice to be developed in conjunction with both Local Authorities and Public Health.

- *Personal Health Budgets (PHBs)*

Work is underway in preparation to implement PHBs from April 2014 within health and social care systems.

- *Liaison Psychiatry*

Develop a system wide model for liaison psychiatry which will include all aspects of Mental Health provision including dementia, learning disability liaison and general support to acute hospitals.

- *Complex needs*

We will review services for people with complex needs and develop a service model that will enable people to access local services in a timely manner.

- *Children with Special Education Needs and Disability*

To work with Local Authority partners to develop integrated systems and processes outlined in the Special Educational Needs and Disability (SEND) green paper, including: - single assessment, joint funding/budget, personalised budgets – for 0-25 year olds with special educational needs, by September 2014.

Notice of Changes and Planned Service Reviews

- **Re-commission community beds configuration as a result of community beds review**
- **Review the impact of the Sub Acute Programme South and (re)commission as appropriate**
- **Commission a Community Geriatrician (older peoples consultant) model to support the primary health care team**
- **Commission community nursing teams to align to GP practices within a 'GP attachment' model**
- **Commission a 'Care Coordinator' model to support patients and carers to navigate the health and social care system**
- **Review CHC processes and arrangements for Adults and Children in order to work with our Local authorities to review areas for integrated working and complete retrospective reviews in line with National frameworks and timelines**
- **Review of Personalised Health Budget national recommendations**

8. Quality in Primary Care

Essential and additional primary medical services through the GP contact, pharmaceutical services, primary ophthalmic services, all dental services, health services for people in prisons, custodial settings and health services for members of the armed forces (registered with DMS) will be commissioning by the NHS Commissioning Board.

The Clinical Commissioning Groups will be responsible for commissioning Local Enhanced Services; secondary ophthalmic services e.g. cataract pathways, health services for offenders serving community sentences and those on probation and health services for veterans or reservists when not mobilized.

Each of the 5 localities will also adopt a strong focus upon improving the quality and productivity of primary care services.

Achievements over the last year:

- *Reducing variation between GPs when making referrals into secondary care*

All localities had made significant improvements to the quality of primary care services by reducing variation between GPs when making referrals into secondary care. GPs have ensured referral pathways are evidenced-based and clinically appropriate, with optimum high quality care being provided within a primary care setting. In addition to these achievements:

- ***Chiltern Vale*** have piloted the community Matron model; providing effective case management for patients with complex care needs and a reduction in emergency admissions, developed 'step up' community beds that provide intensive rehabilitative support as opposed to hospital admission and supported GPS with Care Quality Commission requirements.
- ***West Mid Bedfordshire*** have secured significant clinical engagement within a primary care quality outcomes framework, have continued to improve and develop a number of community based services enabling more people to be treated closer to home, and improved primary care management of long term conditions has resulted in a reduction in emergency admissions.
- ***Bedford*** have led the redesign and implementation of new community-based Diabetes and Chronic Obstructive Pulmonary Disease services, implemented a primary care anticoagulation service which provides outreach care to the housebound and community-based services, supported the Health & Wellbeing teams to address inequalities in care by targeting deprived populations within practices and delivering NHS Health Checks, supported the health & wellbeing teams to develop Health Champion Trainers, undertaken the evaluation of complex care team pilot within residential homes and its impact upon improving care coordination, reducing emergency admissions, medicines optimization etc.
- ***Leighton Buzzard*** GPS have focused on supporting the urgent care pathways developed to support people with complex care needs in the community, ensured that local people have improved access to diabetic retinopathy screening and seen a significant improvement to GP Practice facilities.
- ***Ivel Valley*** GPs have provided GP clinical commissioning leadership of Musculoskeletal, Mental Health and Diabetes redesign projects and patient, public and carer engagement activities, lead

BCCG involvement in the national Macmillan research project which explores GP referral styles and the impact upon early cancer diagnosis, implemented a mental health Link worker to support local population need, supported local and regional project groups with primary care expertise in relation to Enhanced Recovery pathways. The locality has also implemented a preventative social worker project, a joint project with Central Bedfordshire Council.

Priorities and Challenges for 2013/14

- *Driving up the quality of care provided by local care organisations e.g. hospitals, community services etc.*

GP clinical commissioning leads have been identified for larger local care organisations and all localities intend to work closely with these leads to influence improved patient experience, outcomes and quality of care. A focus upon performance management e.g. ensuring services are providing the care and delivering the outcomes intended, improved communication e.g. timeliness and content of discharge summaries, improved information e.g. accuracy of coding are all crucial for GPs to understand and improve commissioning of patient journeys within and through services. In addition to these priorities:

- ***Chiltern Vale*** will continue to ensure referral pathways are evidenced-based and clinically appropriate and also ensure that the care that occurs in hospital is clinically appropriate to an acute hospital setting, will work with programme boards in the local implementation of new services and care pathways for people with musculoskeletal, opthalmology, gynaecology,, mental health, eating disorders and dementia care and intervention needs.
- ***West Mid Bedfordshire*** will work with programme boards in the local implementation of new services and care pathways for people with ophthalmology, dermatology and cardiology care and intervention needs, continue to improve how we help people with urgent care needs through closer working with local community teams, community-based facilities and out of hours GP services, and will take forward a program of work around improving early help and support for people with mental health problems.
- ***Bedford*** will commence multidisciplinary staff team (e.g. district nurse, practice nurse social worker and GP) meetings within GP practices to improve the coordination of care for patients with complex needs, ensure that local clinical care pathways for minor surgery lead appropriately into dermatology services, will work with programme boards in the local implementation of new services and care pathways for people with cardiology, mental health and cancer care and intervention needs, and support the outcomes of the community review.
- ***Leighton Buzzard*** focus on patient, public and carer engagement, ensuring that urgent care pathways are effective for local people by monitoring A&E attendances and emergency hospital admissions, improve the quality of primary care by reviewing any variations in care delivery, improve liaison with local care homes and out of hours care providers to enhance the quality of care.
- ***Ivel Valley***, will work with programme boards in the local implementation of new services and care pathways for people with ophthalmology, mental health and community beds care management, focus upon patient, public and carer engagement initiatives.

9. Prevention

Prevention work has been led by Public Health. From April 2013 Public Health will transfer to Local Authority which encompasses Bedford Borough Council and Central Bedfordshire Council.

Achievements over the last year:

SUBSTANCE MISUSE

- Alcohol Arrest Referral Service & Community Alcohol Liaison Service

These services ensure people with alcohol related problems receive appropriate and timely care and treatment, including referral/signposting on to the appropriate Alcohol treatment service, thereby reducing alcohol related harm and subsequent attendance and admission to hospital. They have implemented new workforce roles including; 2 x Alcohol Outreach Worker2 x Alcohol Arrest Referral Workers and Community Alcohol Liaison workers.

- Adult Substance Misuse Service Redesign

This new service has amalgamated the historic adult services for substance misuse and the adult alcohol services. The Service was successfully tendered and the new provider commenced from Sept 2012.

TOBACCO CONTROL

- Babyclear, Kick Ash and Stop before your Op

These initiatives increase healthy life expectancy for the local population and reduce health inequalities by making it easier for smokers to quit, reduce smoking prevalence and reduce the likelihood that children will become smokers. BabyClear and Kick Ash are now business as usual within their delivery areas and are therefore no longer reportable under QIPP.

Priorities and Challenges for 2013/14

- *NHS Health Checks*

NHS Health Checks is a mandatory deliverable within the Public Health Outcomes framework. This initiative will systematically offer preventative checks to all those aged 40 to 74 years to assess their risk of vascular disease (heart disease, stroke, and diabetes and kidney disease) and this risk will be communicated and subsequent lifestyle and medical management provided.

- *Healthy Weight*

Through public health interventions, stop the year on year increase in levels of obesity, by increasing the population recognition of obesity and related health issues and increase the habitual levels of healthy eating and physical activity.

- *Substance Misuse*

Through public health interventions, ensure that people with substance misuse problems receive timely and appropriate care and treatment, including referral/ signposting onto appropriate substance misuse services. Thereby reducing alcohol related harm and associated A&E attendances.

- *Tobacco Control*

Through public health interventions, continue to support people to stop smoking and hence work towards reducing smoking prevalence within Bedfordshire.

- *Making Every Contact Count*

To deliver systematic brief healthy lifestyle advice and signposting to existing health and social care services at a scale that will lead to improved population health and a reduction in lifestyle preventable disease. The project will target smoking prevalence, obesity, healthy eating and physical activity, prevalence of harmful drinking.

10. Quality, Outcomes and Patient Safety

The objectives for BCCG quality and safety team are to:

- Agree and ensure that indicators relating to patient safety and clinical quality are included in all provider contracts and monitored continuously. This ensures that any early warnings regarding possible deterioration in service quality is identified and acted upon.

- Review and analysis of all quality data and information about providers to ensure recognition of early warning signs e.g. Integrated Performance and Quality Dashboards, Quality profiles and other data/intelligence about providers.

- Review and consideration of relevant published reports or data in relation commissioned providers. Agree corrective action and reporting for any concerns identified.

- Review all information and data including Serious Incidents, Never Events, complaints trends and Serious Case Reviews, ensuring that corrective and preventative action is taken and that lessons learned are widely disseminated

- Ensure providers have processes in place to report incidents in a timely manner.

- Review Safety Alerts and consider implications to commissioned services and ensure providers implement actions within timeframes

- Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services and outcomes for patients

- Review of all patient experience and engagement intelligence to ensure it is utilised to inform and influence the design of services.

11. Working in Partnership – Joint Commissioning

The decrease in public sector funding combined with the current changes in the NHS commissioning landscape mean that now, more than ever, local 'health' commissioners must develop partnership-working approaches.

We are building on existing relationships created by Bedfordshire PCT with social care commissioners in both Bedford Borough and Central Bedfordshire councils, but refreshing them with more clinical input and refocusing on improving both patient outcomes and value for money. Although we have in place joint strategies for the commissioning of key services (such as care for those with mental health conditions), joint commissioning between health and social care services in Bedfordshire is not as advanced today as it is in many other parts of England. This is indicative in part of the significant organizational changes that have taken place, firstly in the move from county/district councils to unitary authorities and then most recently within the NHS. As we enter a period of relative structural stability, external assessors are noting how strong the relationships are between BCCG and BBC and CBC, and all three organisations are expressing clear intentions to accelerate our joint commissioning arrangements. We can start quickly by, for example, using the positive experiences of a successful joint procurement of community equipment to procure more together. Where both the 'health' commissioners and the local authorities have contracts with the same provider (for example, for mental health services and community health services), in 2013-14, we will move to monitor those contracts together and jointly hold those providers to account for the quality and value of services they provide.

In addition to strengthening these existing relationships, we will be creating new commissioning relationships with both public health and the NHS Commissioning Board's Local Area Team (LAT). The local public health team is moving out of the NHS and into the two unitary authorities, taking with them commissioning responsibilities for, amongst other areas, sexual health, substance misuse, and smoking cessation. It would be difficult to commission outcomes for these services without considering the impact on use of emergency departments, general practice, and other CCG-commissioned healthcare resources. Similarly, whilst the CCG retains commissioning responsibility for care of infectious diseases, we are reliant on public health support to ensure our commissioning specifications have taken into account issues such as outbreak management and contact tracing. Therefore, in 2013-14, we will continue to develop our partnerships with the local authority-based public health teams to ensure the fragmentation of commissioning responsibilities does not lead to loss of resilience within overall healthcare provision.

The NHS Commissioning Board LAT is responsible for commissioning primary care services, including general practice, dentistry and optometry, and screening and immunisations. As a CCG, we retain responsibility for improving quality in primary care, vision services overall, and we will also feel the impact of the success or otherwise of screening and immunization programmes. It is therefore in our strong interests to develop close working relationships with the new teams in our LAT, and we look forward to doing so once they are in post.

The place where all health and social care commissioning– CCG, social care, public health and NHS Commissioning Board – comes together in each unitary authority is at the Health and Wellbeing board. Each of the two local Health & Wellbeing Boards served by BCCG have agreed priority areas on which we

will all focus (see section 1). The Boards will hold us to account on our collaborative efforts to address those priority needs, as well as improve the overall health of the local populations. The CCG plays a strong lead role in both Boards already. Each Board has as its vice-Chair, a clinical leader from the CCG: the CCG's chief clinical officer was appointed as vice-chair for Central Bedfordshire's Board, and the Bedford Borough locality chair for Bedford Borough's. Although constituent members of the board were involved in the development of this set of CCG commissioning intentions, in future, as the new commissioning entities (such as the LAT) take shape, we will involve the Boards themselves to a greater extent than has been possible so far in the development of subsequent commissioning intentions.

12. Business rules and contractual proposals

As we move into the contracting round for 2013/14, BCCG would like to draw providers' attention to our headline intentions, business rules and contracting proposals for 2013/14.

The health economy continues to face a period of unprecedented change and financial challenge thereby increasing the need for our providers to deliver both improved productivity and performance. Our aim is to ensure that resources are targeted effectively to maximise patient treatment and care, and that parity of charging and coding exists between providers.

This is not an exhaustive list, and will be further informed by our plans together with the Midlands and East Commissioning Framework and by the recent publication of the Planning Guidance for 2013/14 and CCG financial allocations alongside the Road Test Tariff for 2013/14. However, we thought it would be helpful to draw providers' attention to some of the key areas of focus for the coming year.

Finance

2012/13 was a challenging year financial for the PCT/CCG. During 2013/14 Bedfordshire CCG will be working hard with our partners in the local health system to ensure we balance our books, however it is clear that the challenge will continue into 2014/15 and beyond, with further requirements for improving productivity and ensuring that our commissioning plans are cost effective with no compromise on quality. Providers should therefore ensure that their own plans reflect these requirements, and should not anticipate the same level of income for 2013/14 that they have received in previous years. To achieve financial resilience, reductions on 2013/14 outturn are required across all providers, and further reductions will be necessary in the coming year to ensure the health system is in balance going forward. We expect the system wide QIPP plan and implementation to support the delivery of this.

- Block elements to Cost per Case or shadow – for elements where we currently operate a block arrangement, what remains block or what moves to either cost-per-case from 01 April or use first 6 months to identify appropriate levels, etc.
- Continued process for emergency re-admissions with reduction in contract value to reflect these rates.
- Non PBR Prices (Excluded HRGs/Other non PBR) – comparison with range of other provider prices and discussion on variances. Expectation of national deflator being applied when information is published.
- Where applicable agree a local tariff for 'one stop shop' activity or a local price / pathway price for agreed clinical pathway changes i.e. clinical triage and signposting at A&E.

Contract management

At the current time we continue to assess the full impact of the Planning Guidance for 2013/14 and CCG financial allocations. It is the intention to agree contracts that incorporate the key requirements of these documents once published and we will seek to update our intentions and introduce such national or regional requirements into the discussions as they become available. We will undertake a review of the key schedules within our contracts as per the requirements of the relevant contract Guidance. As a minimum this will include:

- Activity & Finance schedules
- Quality and Performance indicators
- Information requirements
- CQUIN schemes

As part of the transition of responsibility for commissioning to CCGs and other statutory bodies, the CCG requires that all contracted activity, whether PbR or non-PbR, be provided at an individual patient level. In particular, it is essential that all non-PbR activity and costs are attributed to practices at MDS level using the standard practice codes. This will allow all activity and spend to be validated and reconciled to each GP practice at a CCG level to ensure accurate activity and financial performance monitoring. We will stipulate the minimum data requirements that all providers will need to comply with to ensure that data is supplied in a consistent and standardised format to aid and improve performance analysis. Unless specifically agreed in writing in advance of contract signing, BCCG will not pay for any activity which does not meet these minimum requirements to identify a patient and their practice.

Coding & counting

To ensure fairness and parity between all our providers in their coding, counting and charging of service activity, all providers contracted with in 2013/14 will be required to abide by our policies and protocols, including low priority and prior approval, even if these are not consistent with the Trust / Provider host. For clarity, this includes those Trusts where BCCG will not be the host commissioner. Referrals will specify clearly when patients are being referred for a clinical opinion. We intend to adopt any PbR mandatory tariff items, including without limitation, Best Practice Tariffs (payments in respect of the treatment of the individual patient not as a cohort), new Critical Care (adult and neonatal) tariffs and any new PbR terms which link the tariff (or a percentage of the tariff payable) to a delivered outcome.

Where providers claim / seek to claim Best Practice tariff they will need to demonstrate and evidence best practice is being delivered and adherence to the full requirements of the Best Practice tariff.

Coding review/monthly query processes

During 2013/14, BCCG is undertaking a full coding review of activity undertaken at its main providers. This will incorporate a review of local pricing and reference cost submissions by the trust and the application of PbR Guidance. Recommendations from this review will be taken forward in the Activity & Finance plan for 2013/14 and will be incorporated into the CCG's routine query processes.

High costs drugs & devices

Drugs excluded from contracts will be commissioned in line with the Midlands and East Commissioning Arrangements for high cost drugs and devices and processes outlined within this document. This requires providers to use notification and prior approval forms for certain excluded high cost drugs. It also outlines the minimum dataset required to validate high cost drugs and chemotherapy.

If the processes outlined are not followed and if the data fields for Drugs, Devices and chemotherapy (including indication) are not fully completed then BCCG will not fund costs outside tariff. Where a drug is not on the relevant hospital formulary, the secondary care clinician cannot refer back to the patient's General Practitioner for prescription of this drug. BCCG require a full open book accounting and patient administration recording systems on such purchasing.

Productivity metrics

We will seek to build on existing schemes, developing new metrics to support improved quality and patient experience and cost effective use of resources. This will include a review of:

- Surgical threshold policies
- Further Improvement in New to Follow Up Ratios
- Areas for clinical audit
- Low clinical priorities and interventions with limited therapeutic value
- Conversion ratios to be achieved in key areas ie Elective Spells following an Outpatient Appointment and Non Elective spells following an A&E attendance
- Penalties where discharge summaries or outpatient letters are not received or the information contained in this type of correspondence is incomplete, incorrect or missing.

Prior approval schemes, surgical threshold policies and low clinical priorities

BCCG will monitor providers rigorously against all such schemes and where activity is not in accordance with these, payment will not be made.

Discharge communications

We would expect providers to be demonstrating tangible and measurable improvements in the quality of discharge communications from A&E, outpatient, admitted patient care and other services. The quality should include:

- Timeliness – in line with contractual parameters
- Appropriateness – information that is useful to manage patients in primary care
- Diagnostics – information should include what tests have been conducted and what results were found

Treating patients in turn

The CCG will agree with providers appropriate average duration of waits by specialty so as to maintain, as a constant, the throughput in planned care. This is to ensure that as far as is practicable patients are

treated in turn at the specialty level within the 18 week pathway, and that activity is demand and not capacity led.

Consultant to consultant referrals

The CCG will be undertaking a review of its Consultant to Consultant referral protocol and activity under this heading. The aim is to ensure that pathways are clear, patients are referred to the right specialty first time and the number of consultant to consultant referrals is significantly reduced from historic levels. There is an increase in the "other" referral category, and the CCG will be reviewing this to ensure that referrals are appropriate.

Outpatient procedures V day case

The CCG expects that where a procedure can be delivered in an outpatient setting, where appropriate this should be undertaken rather than as a day case. These procedures should be coded accordingly; as a principle BCCG will not pay the day case rate where a procedure should be delivered as an outpatient, unless a clinical justification can be made.

Should there be any subsequent issues that arise that would have a material impact on this contract, we will notify you as soon as possible as part of our contractual negotiations. We look forward to discussing these elements with you and your team in the coming weeks.

Contract Tolerances

To incentivise providers to work together to jointly manage demand and the financial risk associated with it more effectively we will seek to agree contract tolerances and marginal rates for over performance on elective work in addition to any provisions as set out in the 2013/14 PbR guidance or Operating Framework.

OUTLINE APPROACH

13. Summary and conclusions

The BCCG strategic approach to commissioning better value healthcare for Bedfordshire residents is the key focus for moving our strategic intentions for 2013/14 forward. Our commissioning intentions to deliver the vision and commitments outlined in this document will be followed through with robust delivery plans, developed in partnership with providers.

The commissioning intentions outlined in this document will inform contract negotiations for 2013/14; however, amendments may be necessary as the implications of the 'Healthier Together' programme and the Planning Guidance for 2013/14 and CCG financial are fully explored.

We have used the prioritisation process to determine and refine our commissioning intentions to achieve the highest quality health care providing the best patient experience possible within available resources. Where it is determined this is not possible we will work with providers to identify further initiatives, re-commissioning or potential decommissioning required to balance within the funding available. We are an evolving organisation, and as our partnerships with patients and the public, the NHS Commissioning Board, Local Authorities and other clinical commissioning groups mature, our intentions and plans will evolve with us, becoming increasingly responsive to the best patient experience possible within available resource.

NHS

Bedfordshire Clinical Commissioning Group

Appendix 1

You told us....we did!

You told us....we did!

Here are a few examples of some of the plans we are working on because of the things that patients, carers and the public and health care provider organisations and charities told us during the commissioning intentions workshops:

Integrated Care

You told us that today…

- There are a number of different care providers serving one community with inconsistencies in the quality of care that is provided, particularly within the services you pay for
- Services are not joined up, when there are issues with care patients are unsure about which organisation or service this should be raised with.
- There is a lack of continuity of care. People with long term conditions may have times when they are well and need less care; however, if a condition then deteriorates it feels like you start at square one again when you need to access services.
- People should be able to stay in their own home as long as they want
- Care organisations are concerned with who will pay when needs span health and social care
- ***Care pathways are fragmented, they do not integrate, there needs better understanding between care providers about how patient pathways move through services***
- ***There is a lack of financial incentive to integrate care***

That your priority is….

- A care coordinator role that understands the links with Social Services, Charities, Schools, Citizens Advice to direct people to the right care when needed.
- Developing the Primary Care Health team to include older peoples consultants, working alongside GPs, Practice Nurses and district nurses etc. to provide expertise and support for complex care needs
- Patient information systems and care records need to be able to share information across services; *Interoperability to improve integration of IT systems*
- ***Joint contracts for health and social care services that are based on patient outcomes***
- ***Look at the bigger picture; work closely with other Clinical Commissioning Groups which share services, avoid piecemeal changes and fragmented commissioning***
- ***Everyone understands their part of the patient journey***
- ***Carers needs being met***

We did …..

- **Identify Integration of care as key focus for 2013/14.**

An integrated care pathway is a multidisciplinary outline of anticipated care, involving all relevant services and staff, placed in an appropriate timeframe to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes. By listening to both patient's, public, carers and care provider organisations we heard that a number of the service improvements we highlighted were closely linked to providing an integrated, joined up approach to care, e.g. the Care coordinator role and developing multidisciplinary teams within primary care. We heard that small, piecemeal changes have minimal impact upon ensuring that services are joined up and well-coordinated. We have therefore considered each of the service improvements that are interdependent to developing integrated, joined care and included them in a system wide programme of change in order to deliver integrated services.

Bedfordshire CCG will be working with each Local Authority to develop local plans for addressing challenges between health and social care and voluntary services. We expect to deliver a shift in care provision away from acute hospitals toward community settings where it is safe and effective. We will develop commissioning plans for implementing the outcomes and recommendations of the community bed review, which will aim to deliver more joined up care for the benefit of local people and carers. In partnership with local authorities we will implement recommendations within the National Dementia Strategy, which focuses upon early diagnosis and intervention, increased quality of care in general hospitals, living well in dementia care homes and a reduction in inappropriate use of antipsychotic drugs. Where there is joint funding of services, commissioners will come together to jointly manage performance e.g. SEPT community health services.

Care Closer to Home

You told us that today…

- There is not enough access to specialist advice from staff other than consultants e.g. specialist nurses
- That there are gaps in information and advice between the GP and hospital services and then from hospital to home
- GPs need more support and information
- ***There is a lack of capacity to support individuals in the community***
- ***There needs to be increased self-management information and advice***

That your priority is…..

- One stop clinics/services (where you are able to see a specialist e.g. consultant/specialist nurse, have your tests and receive a diagnosis and management plan in one visit) are seen to be a good way to see the right person first time

- GPs with specialist interest seeing patients in the community/surgeries
- That, where clinically appropriate, community based services, closer to people's homes, with specialist multidisciplinary staff and more convenient opening times e.g. evening and weekends is preferred to multiple hospital appointments.
- Access to talk to a suitable clinician on the phone; could be a nurse specialist
- Access to continued care through clinicians that is quick and easy

We did….

- **Commission Care Closer to Home services commencing in 2013/14**

Planned pathways of care are those where people will have planned operations or hospital appointments. In 2013 new services will commence within a range of specialties; musculoskeletal, cardiology, dermatology, vision, urology and gynecology. Services will be provided within community-based settings, closer to people's homes and at times, such as evenings or weekends, which are more convenient. These services will also focus on improved access, offering telephone advice and/or fast track appointments for people with existing long term conditions that may be deteriorating. These services will provide specialist expertise from a range of staff including Consultants, Nurses, physiotherapists etc. Where possible, one stop services will mean people can see the specialist, have tests, and receive a diagnosis and a management plan all on one visit. This means people will not need to visit hospitals for multiple appointments.

Out of Hours Service Review

You told us that today…..

- Increased out of hours support is needed to avoid inappropriate use of A&E
- Extended opening hours should be accessible in all surgeries
- ***Need to redesign the primary care platform to see GPs & Consultants working together***

We did…

We will review these services in order to:

- Examine the impact of extended opening hours of OOH services from 6pm rather than 6:30pm to respond to a peak in activity at this time at A&E as a result of GP surgery closing times.
- Examine the impact of out of hours GP services being able to perform basic diagnostics e.g. ECG and blood tests, on A&E demand.
- -Explore the options for out of hours service provision where there are opportunities to improve patient experience

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Transition from children's services to adult services

You told us that today….

- Teenagers and young people fall between services
- Schools, local authorities and health do not provide a joined up approach to supporting children and young people
- There should be a flow from childhood to adulthood without a disruption in care
- ***That there is a grey area between paediatrics and adult care due to dependence whether an individual is in education***

We did….

Will audit transition pathways for young people to test the effectiveness and implementation of the Multi Agency Transition Tool (MATT), This is a tool which will be used across all agencies (Health, social care and education) to support individual planning needs and ensure smooth transition from children to Adult services.

Key:

Patients, Carers and Public Deliberative Event feedback: Is in plain font

Health Care Provider and Charities Deliberative Event feedback: ***Is in italic font***

NHS

Bedfordshire Clinical Commissioning Group

Appendix 2

Commissioning Intentions Outline

By Domain, BCCG Vision and Local Authority

NHS Outcomes Framework Domains	*BCCG Key Area of Focus & Cross Cutting Themes*	*Central Bedfordshire Borough Council*	*Bedford Borough Council*
Preventing people from Dying Prematurely	**Care Right Now**	• *Falls Prevention* • *Out of Hours Dressings* • *Out of Hours GP services* • *Maternity Tariffs*	• *Review of walk-in centre services* • *Falls Prevention* • *Out of Hours Dressings* • *Out of Hours GP services* • *Maternity Tariffs* • *Looked After Children*
Enhancing quality of care for people with long term conditions	**Care For My Condition Into The Future**	• *Musculoskeletal Services* • *Cardiology* • *Ophthalmology* • *Dermatology* • *Gynaecology* • *Neurological disorders* • *Stroke* • *Cancer Pathways* • *Community Mental Health Teams* • *Primary Care Mental Health Services* • *Dementia* • *Multi-Agency Transition Tool* • *Children with Long Term Conditions* • *Medicines Management* • *Looked After Children*	• *Musculoskeletal Services* • *Cardiology* • *Ophthalmology* • *Dermatology* • *Neurological disorders* • *Stroke* • *Cancer Pathways* • *Community Mental Health Teams* • *Primary Care Mental Health Services* • *Dementia* • *Multi-Agency Transition Tool* • *Children with Long Term Conditions* • *Medicines Management*

Helping people recover from episodes of ill health or injury	**Care When it's Not That Simple**	• *Integrated Care* • *Personal Health Budgets* • *Liaison Psychiatry* • *Complex needs* • *Children with Special Education Needs and Disability*	• *Integrated Care* • *Personal Health Budgets* • *Liaison Psychiatry* • *Complex needs* • *Children with Special Education Needs and Disability*
Ensuring that people have a positive experience of care	**Safety & Patient Experience**	• *Review of all patient experience and engagement intelligence to ensure it is utilised to inform and influence the design of services.*	• *Review of all patient experience and engagement intelligence to ensure it is utilised to inform and influence the design of services.*
Treating and caring for people in a safe environment and protecting them from avoidable harm	**Safety & Patient Experience**	• *Patient safety & clinical quality indicators in all care provider contracts* • *Analysis of quality of quality data and information from providers to ensure early detection of quality issues* • *Review of all serious incidents, events and complaints, ensuring corrective and preventative action is taken and lessons learned are widely disseminated* • *Review Safety Alerts and published reports and consider implications to commissioned services and ensure providers implement actions within timeframes* • *Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services and outcomes for patients*	• *Patient safety & clinical quality indicators in all care provider contracts* • *Analysis of quality of quality data and information from providers to ensure early detection of quality issues* • *Review of all serious incidents, events and complaints, ensuring corrective and preventative action is taken and lessons learned are widely disseminated* • *Review Safety Alerts and published reports and consider implications to commissioned services and ensure providers implement actions within timeframes* • *Ensure that Commissioning, Quality and Innovation (CQUIN) proposals are appropriate, challenging and lead to significant improvement in quality of services and outcomes for patients*

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Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	A briefing on the Troubled Families Programme
Meeting Date:	31 January 2013
Responsible Officer(s)	Edwina Grant, Deputy Chief Executive/Director of Children's Services
Presented by:	Cllr Richard Stay, Executive Member for External Affairs

Action Required: The Board is asked to:

- Receive this briefing in advance of their consideration of the report on the implications of the Troubled Families Programme on the NHS.

Executive Summary	
1.	The attached briefing note is intended to advise members of Health and Wellbeing Board of the aims and objectives of the Troubled Families Programme. This will inform the discussion on the implications of the Troubled Families Programme on the NHS, set out in the next item.

	Conclusion and next steps.
2.	To discuss the programme in advance of considering the implications for the NHS.
Strategy Implications	
3.	This report relates to the following three cross cutting priorities in the Health and Wellbeing Strategy: • Improved outcomes for those who are vulnerable • Early Intervention and Prevention • Improved mental health and wellbeing The report also relates to the following specific priorities: Priority 7: Helping people make healthy lifestyle choices Priority 8: Improving mental health for children and their parents Priority 9: Improving mental health and wellbeing of adults

Governance & Delivery	
4.	Reports on progress go to Central Bedfordshire Together which oversees the delivery of the Programme.
Management Responsibility	
5.	Responsibility for ensuring that action is taken to meet the Health requirements of the Troubled Families Programme rests with Bedfordshire Clinical Commissioning Group and Public Health.

Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Failure to deliver good outcomes for those on the Troubled Families Programme	Possible	Significant	Delivery of the programme plan

Source Documents	**Location (including url where possible)**
The Troubled Families Programme	Department for Communities and Local Government

Presented by Cllr Richard Stay

Troubled Families (TF)

Background

- The Department of Communities and Local Government launched the Troubled Families initiative in December 2011 to improve the outcomes for an estimated 120,000 families identified as having the greatest need. Louise Casey leads this work nationally and has worked across two Governments, known for a "tough love" approach to families.

- The Troubled Families programme is built on the Family Intervention Programme in deprived areas and two Early Intervention Reports from Graham Allen MP, working with Iain Duncan Smith MP.

- Troubled Families are defined by the DCLG as:
  "households who are involved in crime and anti social behaviour; have children not in school, at least one adult on 'out of work' benefits and cause a high cost to the public purse" (it is open to local partnerships to add an additional criteria at this stage. Central Bedfordshire have not done so).

  - It is estimated that each troubled family cost an average of £75.000 per year. Intervention will vary from the families known to all agencies to those who can be picked up early and where a relatively small intervention will save public money and family trauma later on. Based on the DCLG calculation it is suggested that Central Bedfordshire has approximately 254 troubled families eligible for the 'payment by result' programme but the criteria is expected to identify over 300.

Central Bedfordshire – activity to date

- Received £340,600 for the financial year 2012/13.

- We have submitted monthly returns to the Troubled Families Unit in the DCLG , work is judged to be on track.

- The Launch Conference in Central Bedfordshire on 9 October was addressed by the Leader and others – well received.

- First families have been identified, from data provided by council departments and the police, and have been mapped across the authority. The second data trawl is currently in progress and will be matched by the end of December. It should be noted that the DWP data was not made available for the first match but will be in the second. It is expected that 85 families will be identified in this first year.

Governance

- Each Council needs a Programme Board which is usually chaired by the Chief Executive or Director of Children's Service and occasionally by a joint Director of Community Services. (In Central Bedfordshire, the DCS is the Chair, as in 80% of other Councils).

- There will be a Troubled Families Coordinator appointed (Clare Dan) who will take up post working in Children's Services Operations with effect from 10 January 2013. She will work to support the Assistant Director Children's Services Operations who take the professional lead and be the accountable officer for this project. Until the new Assistant Director Children's Services Operations arrives, Sue Gregory will undertake this work as Senior Social Worker.

- The Operational Programme Board includes representatives from key partner agencies and should facilitate the bringing together of activity to support the Council across the geographical area. Below this, it is proposed to have operational groups coordinating activity in the North and South of Central Bedfordshire.

Central Bedfordshire Governance

- This is through the Chief Executive and politically, Cllr Richard Stay, Executive Member for External Affairs, to Central Bedfordshire Together (CBT). This is not a Children's Services activity, it is a partnership activity

Financial Implications

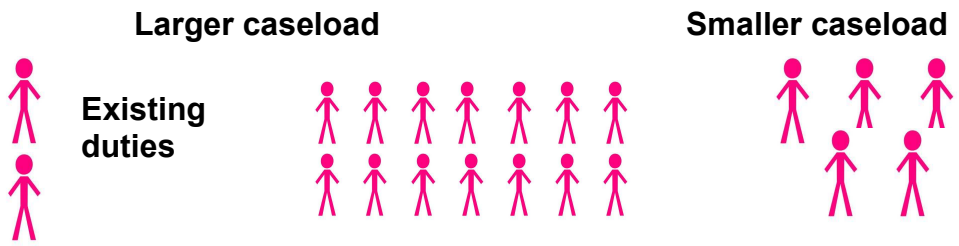
- DCLG estimate each family will need an average £10k to fund tailored, effective services and interventions. However, the payback is estimated nationally to be between £75k and £250k per family per annum, mostly in reactive costs.

- 60% of costs are to be borne by local authority and partners.

- 40% of costs are available from DCLS as part of a payment by results scheme.

Degrees of the Family Intervention Service – there is a sliding scale

Extent of family problems/family causing problems



FAMILY INTERVENTION *'super light'*	FAMILY INTERVENTION *'light'*	FAMILY INTERVENTION *'intensive'*
Named lead for family with dedicated time from home agency	Less intensive work with larger caseloads. 15 at any one time.	Intensive work with small caseloads of families, e.g. <5

What is family intervention?

- Style of working with very troubled families
- Original model well evidenced, consistently strong outcome data since 2006/7.
- It is highly interventionist and gives families a clear set of contracts and a focused plan towards outcomes.
- Data from the National Centre for Social Research on families (5,500) to have left the programme shows:
  - ASB: 59 % reduction
  - Child abuse issues (neglect, emotional, physical and sexual) 36 % reduction
  - Education: 52 % reduction (truancy, exclusion or bad behaviour at school)
- It is expected that significant interventions be made to families by 2015.

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Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	The Implications of the Troubled Families Programme on the NHS
Meeting Date:	31 January 2013
Responsible Officer(s)	Edwina Grant, Deputy Chief Executive/Director of Children's Services
Presented by:	Edwina Grant, Deputy Chief Executive/Director of Children's Services

Action Required: The Board is asked to:

- Consider and comment on the implications for Health of the Troubled Families Programme.

Executive Summary	
1.	This report looks at the implications for Health Services of the Troubled Families Programme in Central Bedfordshire. The report is presented to the Shadow Health and Wellbeing Board for discussion and action.

Background	
2.	The Government has instituted a Troubled Families programme designed to "turn around the lives" of 120,000 of the most troubled families nationally by 2015. While it is not a statutory requirement for Local Authorities to have a Troubled Families Programme, the Prime Minister and ministers have publicly supported it as a key initiative for the government. It is estimated that these families, which will typically suffer multiple and complex difficulties, cost the public services on average £75,000 a year. The programme is designed to operate primarily on a payment by results basis to incentivise local authorities and others to take action to turn around the lives of troubled families in their local area.
3.	A Troubled Family is defined by the Government as households which: 1) are involved in crime and anti social behaviour. 2) have children not in school. 3) have an adult on out of work benefits. 4) cause high cost to the public purse.

4.	The Department for Communities and Local Government (DCLG) has estimated that there are 305 such families in Central Bedfordshire, with 254 of these families expected to be eligible for funding within the payment by results element of the programme. There is an expectation that 85 families are worked with as part of the programme during Year 1.
5.	There are many potential benefits for Central Bedfordshire, including reduced duplication of services, preventing the escalation into more resource intensive specialist services and improved outcomes for children and adults. Specific outcomes required to meet the payment by results funding include: • ensuring children are back into school; • reducing criminal and anti-social behaviour; and • helping adults back into work.
6.	While Local Authorities are expected to lead the development and delivery of the Troubled Families Programme, it is essential that the programme is seen as a partnership responsibility. A conference was held on 9 October 2012 as a launch event for the Council and partners.
7.	Strategic leadership and management of the programme in Central Bedfordshire are located in Children's Services. A programme co-ordinator will be in post from the 10 January 2013. A Programme Board chaired by the Deputy Chief Executive/Director of Children's Services has been set up. Two multi agency operational groups (north and south) chaired by the programme co-ordinator are being established.
Issues	
8.	The potential impact of the Troubled Families programme is across a range of Health related issues including: 1. Adult and Children's Mental Health. 2. Lack of exercise/poor diet/obesity (linked to worklessness). 3. Drug and substance misuse. 4. Drinking problems or alcoholism. 5. Teenage Pregnancy. 6. Domestic Abuse and Violence. 7. Safeguarding Children and Vulnerable Adults. 8. Sexual Health. 9. Childhood immunisations. It is recognised that families fitting the profile of a Troubled Family are often 'chaotic users' of Health services. This can include them not accessing relevant services or, conversely, overusing services such as GP and Accident and Emergency services.
9.	The approach to the programme will be to ensure that there are: • Named workers for identified families; • Persistence with families backed up by rewards and sanctions; • A common endeavour among agencies for each family, operating within agreed structures.

	Conclusion and next steps.
10.	Work will need to be done to: • identify the appropriate Health professionals for the families; • clarify the role of specific health professionals such as Health Visitors; • establish operational links to services, including mental health, drug and alcohol teams.
Strategy Implications	
11.	This report relates to the following three cross cutting priorities in the Health and Wellbeing Strategy: • Improved outcomes for those who are vulnerable • Early Intervention and Prevention • Improved mental health and wellbeing The report also relates to the following specific priorities: Priority 7: Helping people make healthy lifestyle choices Priority 8: Improving mental health for children and their parents Priority 9: Improving mental health and wellbeing of adults
Governance & Delivery	
12.	Reports on progress go to Central Bedfordshire Together which oversees the delivery of the Programme.
Management Responsibility	
13.	Responsibility for ensuring that action is taken to meet the Health requirements of the Troubled Families Programme rests with Bedfordshire Clinical Commissioning Group and Public Health.

Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Failure to deliver good outcomes for those on the Troubled Families Programme	Possible	Significant	Delivery of the programme plan

Source Documents	**Location (including url where possible)**
The Troubled Families Programme	Department for Communities and Local Government

Presented by Edwina Grant

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Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Health Inequalities in Central Bedfordshire
Meeting Date:	31 January 2013
Responsible Officer(s)	Muriel Scott, Director of Public Health
Presented by:	Muriel Scott, Director of Public Health

Action Required:

1. To consider the Health Inequalities in Central Bedfordshire Public Health Report, its recommendations and suggested actions to ensure implementation.

Executive Summary	
1.	This paper and accompanying report highlight the health inequalities that exist in Central Bedfordshire. Health inequalities exist across the whole life-course. In the more deprived areas; it is more likely that babies will be brought up in a household where someone smokes and they are less likely to be breastfed; Children are more likely to be obese and suffer injuries; Teenagers are more likely to have poorer educational attainment and there are more teenage conceptions; Adults are more likely to die young from circulatory diseases, respiratory diseases or cancer.
2.	To reduce inequalities in health, a number of recommendations are given for Central Bedfordshire Council, Bedfordshire CCG, and local GPs and other providers such as the acute hospitals and providers of mental health and community services (SEPT) These include: • Ensuring early access to antenatal care, reducing smoking in pregnancy and increasing breastfeeding • Improving the wider determinants of health in deprived areas such as educational attainment, housing and employment • Reducing smoking, obesity and harmful drinking of alcohol • Identify those at risk of disease earlier e.g. through NHS Health Checks • Take account of health inequalities in commissioned services, e.g. ensuring equitable access to high quality care • Maximise opportunities for secondary prevention e.g. through Making Every Contact Count (MECC)
3.	To ensure that progress is made towards reducing health inequalities,

	implementation of the recommendations will assured through: • Contract negotiations and performance review meetings with providers to include targets which will help to address health inequalities, for example ensuring that community services deliver good outcomes in each area of Central Bedfordshire and for each vulnerable group • Providing an assessment of outcomes by deprivation at a GP practice level, to ensure that the quality of primary care and outcomes are as good in the most deprived areas as they are in the least deprived areas. • Conducting health equity audits of access to services to ensure that services are delivered according to need • Ensuring that other associated strategies take account of and address inequalities e.g. the Leisure Strategy provides good access to leisure opportunities in the most deprived areas • Measuring progress against the current baseline at least annually and identifying any areas where progress has not been made. Aspiring to achieve targets and outcomes on average will not be enough, they should be achieved in all areas irrespective of deprivation e.g. early access to antenatal care or educational attainment • Considering an integrated approach across agencies – the families at greatest risk of health inequalities are likely to be in contact with several agencies and have the challenge of navigating the different systems. The troubled families programme may deliver learning which could be applied to reducing health inequalities.

Background	
4.	The report looks at inequalities by comparing the most deprived 20% of the population with the other 80%. Although on average Central Bedfordshire has low levels of deprivation compared to England there are 3 areas (LSOAs) in the most deprived 10%-20% in England and 6 areas in the most deprived 20%-30%.
5.	An overall measure for health is life expectancy at birth – both males and females in Central Bedfordshire have longer life expectancy than the England average. However, there are gaps in life expectancy between the most and the least deprived of 7.4 years for males and 5.5 years for females. Although these are not as large as the England average (8.9 years for males ad 5.9 years for females) these are still large enough to warrant concerted action. The report investigates the components of the reduced life expectancy and considers the factors that lead to it.

Issues	
Strategy Implications	
6.	Reducing health inequalities should provide an economic benefit in the long term. The Marmot Review estimated that in England, if everyone had the same health outcomes as the richest 10% of the population this would: • Reduce productivity losses by £31-33 billion per year • Reduce welfare payments and increase tax receipts by £20-32 billion per year • Reduce direct NHS healthcare costs (which account for about one third of

	the NHS budget) by £5.5 billion per year. The very best case estimate for Central Bedfordshire, based on the population size the figures would be: • £150-160 million reduced productivity losses • £98-156 million saved on welfare payments and gained on tax receipts • £27 million saved on direct NHS healthcare costs These are likely to be significant over estimates because deprivation is much lower in Central Bedfordshire than across England. There is limited evidence on how quickly these economic benefits might be realised once interventions are put in place. For example, quitting smoking considerably reduces the risk of a heart attack within months, but improving early years development might take a few years to produce improved educational attainment and a couple of decades to result in fewer NEETs and unemployed. Improving the nutrition of girls and young women will have benefits for their health as well as their babies, but the full economic benefit of their improved health would only be seen when those babies are in their 50s and 60s when they don't have to stop working before state retirement age due to ill health.
7.	It is important to tackle health inequalities across the social gradient proportionate to need; not just trying to raise the health of the bottom 10%, but trying to improve the health of everyone who is not as healthy as the most advantaged in our community. Resources will need to be allocated proportionate to need and in the areas where the greatest improvement is required which will require commissioners to determine how need varies across Central Bedfordshire and to monitor activity at a finer level than they may have been used to historically. This may require some organisations to collect data in a different way so that inequalities can be seen. Ultimately it may be that some existing services or commissions will need to be reconfigured.
8.	The actions outlined in paragraph 3 provide suggested mechanisms for assurance that health inequalities will be reduced. The board are asked to consider whether there are additional actions it would want to see implemented.

Risk Analysis

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Financial settlements for partners may directly impact upon the delivery of the recommendations	Medium	Medium	Commissioning arrangements to ensure provision across the social gradient proportionate to need within budget constraints. Decisions about investment and disinvestment will be based on evidence of effectiveness and impact
The Health	Medium	Medium	A communication plan to ensure

Inequalities report does not influence the commissioning decisions of partners			that partners are aware of the final strategy is being developed and capacity has been identified within the Public Health Team to deliver this. The Equality and Diversity assessments could be examined to ensure that they take account of health inequalities as well as protected characteristics.

Source Documents	**Location (including url where possible)**
'Fair Society, Healthy Lives', The Marmot Review. Strategic Review of Health Inequalities in England post-2010. February 2010. ISBN 978–0–9564870–0–1	http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
JSNA - Joint Strategic Needs Assessment	Central Bedfordshire Council's website http://www.centralbedfordshire.gov.uk/health-and-social-care/jsna/joint-strategic-needs-assessment-jsna.aspx

Presented by Muriel Scott

Central Bedfordshire

NHS

Bedfordshire Clinical Commissioning Group

Health Inequalities in Central Bedfordshire

A report by the Director of Public Health





Muriel Scott
November 2012

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Summary

This report summarises health inequalities in Central Bedfordshire. It is a striking fact that in Central Bedfordshire the most deprived males live on average 7.4 years fewer than the least deprived. For women, the difference is 5.5 years.

Health inequalities are not inevitable and through concerted effort they can be prevented. This report demonstrates inequality by comparing health between the 20% most deprived and the 80% least deprived, but it is important to remember that inequalities exist across the whole range of deprivation.

The report also recognises the major contribution that the wider determinants of health, such as housing, fuel poverty and sustainable development, make to health inequalities, although it is not currently possible to quantify their impact directly.

The key findings from the report are that:

- The pattern of premature mortality across Central Bedfordshire confirms that health is worst in the most deprived areas.
- There is a significant and growing gap in life expectancy between the 20% most deprived and the rest of the population, for both men and women.
- Circulatory diseases, cancers and respiratory diseases are significant contributors to the life expectancy gap, as they are to overall life expectancy. Compared to males, females are disproportionately affected by respiratory diseases.
- The data suggest inequalities among the 20% most deprived compared with the 80% least deprived for: babies living with a smoker; breastfeeding rates; child obesity at age 11; injuries to children and young people; teenage conceptions; education attainment at key stage 4; unemployment (out of work benefit claimants) and smoking prevalence.
- There are inequalities in child development and educational attainment from age 5 to age 16. The gap is larger for older children.
- Central Bedfordshire is better[1] than the England average for the proportion of people in households in receipt of means-tested benefits; inequality in percentage receiving means-tested benefits and young people not in employment, education or training.

In a fair and prosperous society, everyone should have the same chance to lead a long and healthy life. This report shows that significant inequalities exist within Central Bedfordshire and therefore challenges all those who can influence health to take action. This includes Central Bedfordshire Council, Bedfordshire Clinical Commissioning Group, Local Hospitals, South Essex Partnership Trust and individual general practices. All will need to consider what action they can take to start reducing these inequalities.

1 At a statistically significant level

Recommendations

In the first instance, the following recommendations are made:

1. **Central Bedfordshire Council** and the **Public Health directorate** should:
   a. Give every child the best start in life by ensuring early access to antenatal care, reducing smoking in pregnancy and the number of babies living with a smoker, increasing breastfeeding and reducing childhood obesity.
   b. Improve the wider determinants of health such as housing, employment, child poverty, educational attainment, and the natural environment.
   c. Secure high quality alcohol and drug prevention and treatment services for our most vulnerable residents.
   d. Continue to deliver on public health targets which influence health inequalities such as teenage pregnancy rates, smoking in pregnancy, obesity and NHS health checks.
   e. Increase access to the Stop Smoking service for the populations with the highest smoking prevalence and premature mortality rates by providing additional support to practices serving these people and by setting and monitoring challenging quitter targets.
   f. Produce tailored information on health inequalities for GP practices in the most deprived areas and make practice-specific recommendations for evidence-based action.
   g. Make Every Contact Count by ensuring that relevant frontline council staff have received MECC training.

2. **General practices** in Central Bedfordshire should:
   a. Overachieve on smoking cessation targets, with a focus on practices in the most deprived areas
   b. Ensure performance targets for NHS health checks are met and that health checks are of high quality to ensure early diagnosis and management of risk factors for cardiovascular disease
   c. Make Every Contact Count by ensuring that all frontline staff have received MECC training.

3. **Bedfordshire Clinical Commissioning Group** should:
   a. Take account of health inequalities in all the services it commissions, for example by ensuring access to high quality cardiac care exist in the most deprived areas and access to secondary care is equitable across the Central Bedfordshire
   b. Build public health targets into the contracts held by provider trusts where these do not already exist, and actively monitor them
   c. Commission high quality healthcare for vulnerable groups such as looked-after children, young offenders and Gypsies & Travellers.

4. **Other providers**, such as **Bedford Hospital Trust, Luton and Dunstable Foundation Trust Hospital** and **South Essex Partnership Trust** (SEPT) should:
   a. Maximise their opportunities for secondary prevention, starting with users of cardiac, respiratory and cancer services
   b. Make Every Contact Count by ensuring that all frontline staff have received MECC training

c. Ensure that recommendation 6 of NICE guidance PH10 (Smoking cessation) is comprehensively implemented and monitored
d. Ensure that recommendations 6-12 of NICE guidance PH24 (Preventing harmful drinking) are comprehensively implemented and monitored.
e. Deliver other public health targets within contracts

5. **The Health and Wellbeing Board** should:
   a. Monitor the member organisations' progress against these recommendations and ensure that the health and wellbeing strategy is delivered proportionate to need.

1 Introduction

Health inequalities are differences in health between two or more communities or populations. This term is often used as a way of identifying inequalities that are either avoidable or regarded as unfair in some way. In a fair and prosperous society everyone should have the same chance to lead a long and healthy life. Vulnerable groups, such as people suffering from mental health problems and those with learning disabilities, can also suffer poorer health outcomes than the rest of the population.

This report describes health inequalities which have been observed between geographical areas within Central Bedfordshire, particularly in relation to deprivation. Other health inequalities, which are known about through national studies, may well occur in Central Bedfordshire but without local evidence we cannot be sure. Health inequalities suffered by vulnerable groups are not within the scope of this report but are fully documented in the Joint Strategic Needs Assessment[2].

The 2010 Marmot Review, Fair Society, Healthy Lives[3], proposed an evidence based strategy to address the social determinants of health - the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The Review identified six objectives to reduce inequalities in health:

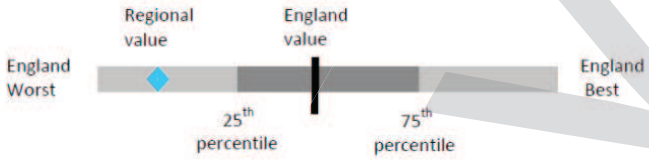
1. giving every child the best start in life.
2. enabling all children, young people and adults to maximize their capabilities and have control over their lives.
3. creating fair employment and good work for all.
4. ensuring a healthy standard of living for all.
5. creating and developing sustainable places and communities.
6. strengthening the role and impact of ill-health prevention.

The Marmot Review estimated that the annual cost of health inequalities in England was between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS. Pro-rata to the Central Bedfordshire population this would be £176 to £195 million, although the figure will be considerably lower than this as inequalities in Central Bedfordshire are not as large as across England. Marmot recognised that action can neither be taken at a general population level, nor be aimed solely at those who have the worst health outcomes and experiences, but should be directed in proportion to the level of need. As a result of the Review, a set of 10 key Marmot Indicators are produced each year by the UCL Institute of Health Equity. Figure 1 summarises the Marmot Indicators for Central Bedfordshire for 2012.

2 www.central bedfordshire.gov.uk/health-and-social-care/jsna/joint-strategic-needs-assessmentjsna.aspx
3 http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

Figure 1: Marmot Indicators for Central Bedfordshire compared with England, 2012

- Significantly better than the England value
- Not significantly different from the England value
- Significantly worse than the England value



	Indicator	Local Authority Value	Regional Value	England Value	England Worst	Range	England Best
	Health outcomes						
	Males						
1	Male life expectancy at birth (years)	79.5	79.6	78.6	73.6		85.1
2	Inequality in male life expectancy at birth (years)	7.4	7.4	8.9	16.9		3.1
3	Inequality in male disability-free life expectancy at birth (years)	5.6	9.1	10.9	20.0		1.8
	Females						
4	Female life expectancy at birth (years)	83.0	83.2	82.6	79.1		89.8
5	Inequality in female life expectancy at birth (years)	5.5	5.3	5.9	11.6		1.2
6	Inequality in female disability-free life expectancy at birth (years)	5.1	8.0	9.2	17.1		1.3
	Social determinants						
7	Children achieving a good level of development at age 5 (%)	55.3	55.5	58.8	49.5		71.4
8	Young people not in employment, education or training (NEET) (%)	5.2	6.4	6.7	12.3		2.6
9	People in households in receipt of means-tested benefits (%)	8.5	11.5	14.6	32.8		4.7
10	Inequality in percentage receiving means-tested benefits (% points)	17.2	23.3	29.0	55.1		4.6

Source: UCL Institute of Health Equity, www.instituteofhealthequity.org and London Health Observatory, www.lho.uk

In summary:

- In 2012 Central Bedfordshire was significantly better than the England value for all 7 indicators marked with a green dot.
- Central Bedfordshire was better than England, but not significantly, for inequality in male and female life expectancy at birth (black dots), however there is a significant and growing gap between the most deprived and the rest of the population.
- Central Bedfordshire was significantly worse than England for children achieving a good level of development at age 5[4], however, 2012 provisional data shows improvement has been made.

Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Thus, the highest priority is attached to the first objective: giving every child the best start in life.

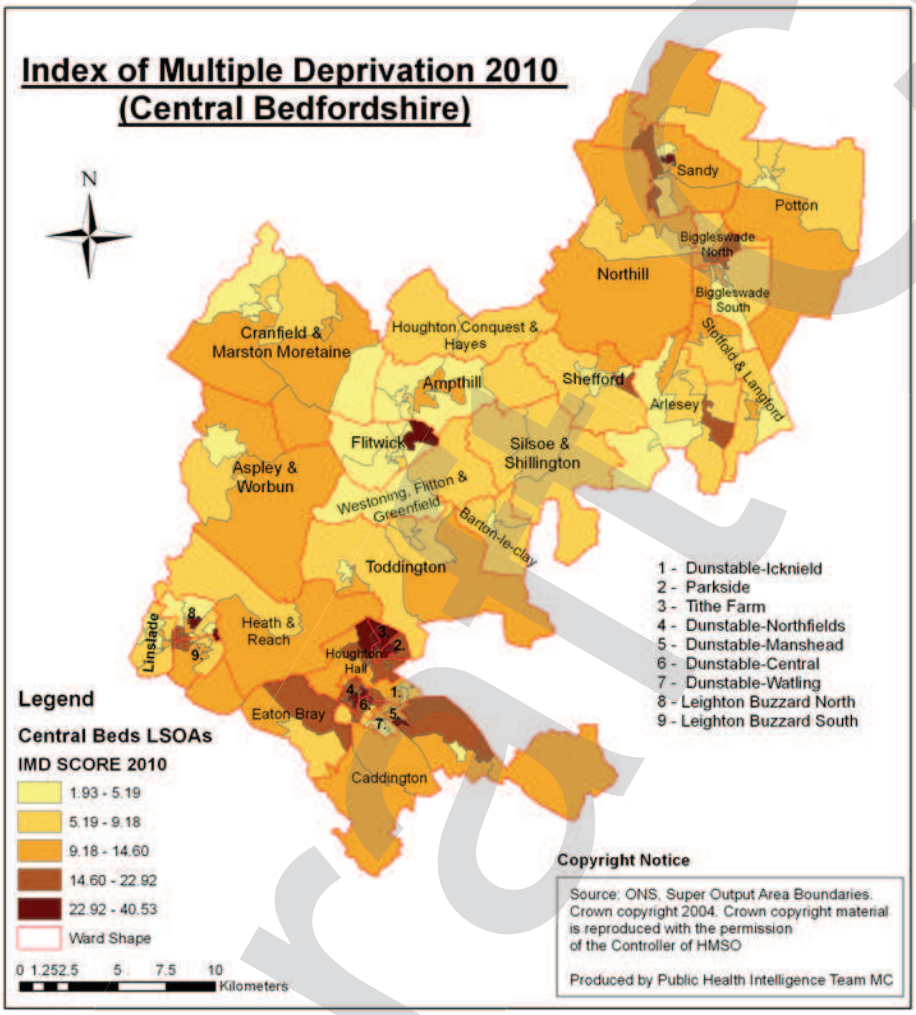
4 Percentage of children assessed by a teacher at Early Years Foundation Stage Profile (EYFSP) as having achieved a 'good level of development' in the year they turn five. 2011 Source: Department for Education

2 Inequalities and deprivation by geographical area

For small area statistics Lower Super Output Areas (LSOAs) are used. There are 154 LSOAs in Central Bedfordshire with an average population of just under 1,660. The level of deprivation in an LSOA is given by the Index of Multiple Deprivation (IMD)[5]. In Central Bedfordshire the LSOA IMD scores range from 1.93 to 40.53, the higher the score the higher the deprivation.

Central Bedfordshire is less deprived on average than England and the east of England. Central Bedfordshire has an average IMD score of 10.73, ranking it in the least deprived 20% of local authorities. The least deprived local authority has a score of 9.99 and the most deprived a score of 43.45

Figure 2: Map showing distribution of index of multiple deprivation in Central Bedfordshire.



Data source: Department for Communities and Local Government, Indices of Deprivation 2010

5 The IMD is built up from 7 components (Crime & Disorder, Barriers to Housing and Services, Education Skills and Training, Living Environment, Health Deprivation and Disability, Employment, Income) and the weighted average gives the overall IMD score for each LSOA.

The most deprived 20% of LSOAs within Central Bedfordshire are those shaded in the two[6] darkest colours on the map (Fig 2) with an IMD score over 14.60. None of Central Bedfordshire LSOAs are in the most deprived 10% in England but three LSOAs (with a total population of 5,200) are in the most deprived 10-20% and a further six LSOAs (with a total population of 10,100) are in the 20-30% most deprived nationally.

Although the overall IMD shows only a few areas are deprived in comparison with England some of its components show a wider impact in Central Bedfordshire. For example 5.25% of the Central Bedfordshire population (some 13,400 people) are in the most deprived 10% in England for Education Skills and Training. The areas affected by this component of deprivation are largely the same as affected by overall IMD.

In addition to the IMD and its sub-domains there are two additional indices: Income Deprivation Affecting Children Index (IDACI) and Income Deprivation Affecting Older People Index (IDAOPI). The IDACI shows a greater proportion of the child population are affected by income deprivation compared to the overall IMD and compared to the income component of IMD.

LSOAs can be grouped together to give more stable statistics. One way to do this is to combine the data from the 20% most deprived LSOAs and compare the figure produced with that generated by combining the data from the other less deprived 80% of LSOAs. In this report, wherever possible, health inequalities are assessed in this way. When particular 'hot-spot' areas have been identified these are also noted.

6 The thresholds for the colours on the map are set to show the range of the IMD scores which are wider at the higher levels of deprivation. There are 12 LSOAs in the darkest category and 19 LSOAs in the next darkest group, which makes a total of 31 – approximately one fifth of the LSOAs in Central Bedfordshire.

3 Life expectancy and mortality

3.1 Inequalities in life expectancy

The overall health of a population can be measured using life expectancy at birth. This takes into account the current rates of death in all age-bands. The smallest areas that life expectancy has been calculated for are MSOAs, which are local groupings of LSOAs.

Inequalities in life expectancy across the whole range of deprivation in a population are measured by the Slope Index of Inequalities (SII). This is used in the Marmot Indicators for Local Authorities. The SII is calculated by grouping LSOAs into tenths by deprivation, and calculating the life expectancy for each tenth. The best-fit straight line is computed and its slope gives the SII. The higher the SII the greater the health inequality within the area. A slope of zero means that life expectancy does not vary with deprivation. However, an SII of 10 years indicates that life expectancy for the most well off is, on average, 10 years higher than for the least well off.

Table 1 shows that, using data for the five-year period 2006-10, Central Bedfordshire had lower inequalities for life expectancy than England for both males and females, however, the differences are not statistically significant.

Table 1: Inequality in life expectancy at birth in Central Bedfordshire

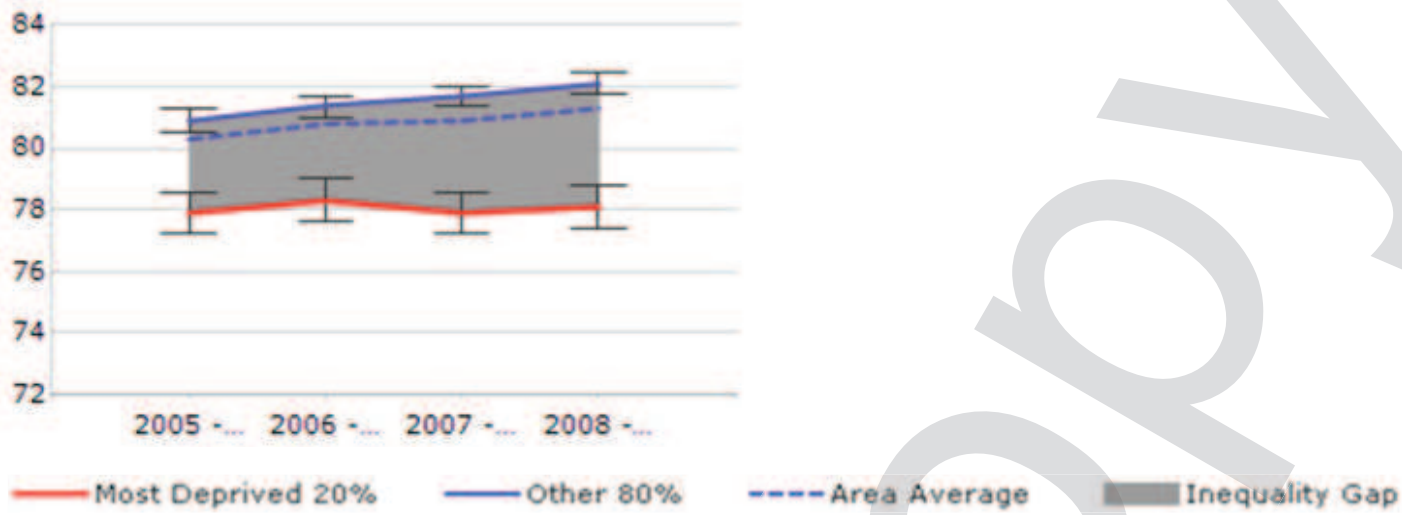
	Inequality in life expectancy at birth, SII (years)[7] for 2006-10		
	Central Bedfordshire	England value	England LA range
Male	7.4	8.9	3.1 - 16.9
Female	5.5	5.9	1.2 - 11.6

Source: Marmot Indicators for Local Authorities in England, 2012 - Central Bedfordshire UCL Institute of Health Equity, www.instituteofhealthequity.org

Although it does not show the entire variation across society, the extremes can be highlighted by calculating the life expectancy for the 20% most deprived and comparing with the other less deprived 80%. Figure 3 shows the trend in three-year pooled data, and suggests that the inequality in life expectancy between the less deprived and most deprived is widening. There is a statistically significant and growing gap between the most deprived 20% and the least deprived 80% within Central Bedfordshire. Health inequalities are widening because life expectancy in the deprived 20% is static, but in the other 80% it is improving year on year. This is true for both males and females.

7 Source: The Public Health Observatories in England, based on analysis of ONS mortality data and population estimates & Department for Communities and Local Government, Indices of Deprivation 2010.

Figure 3: Trends in life expectancy at birth (years) in Central Bedfordshire (persons)

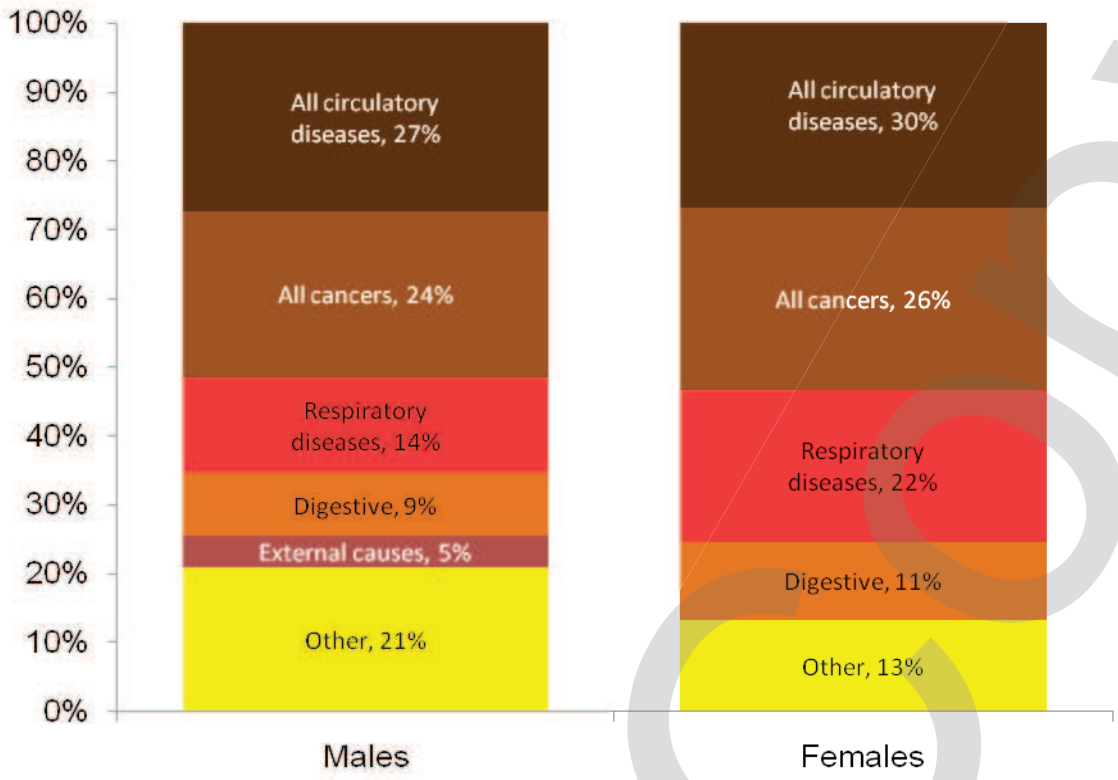


Source: ERPHO fingertips: http://fingertips.erpho.org.uk/

3.2 Inequalities in all cause mortality

Figure 4 shows which diseases are causing the difference in mortality between the most deprived 20% and the least deprived 80%. It shows the proportions of deaths due to the 'big killers', i.e. circulatory diseases, cancers and respiratory diseases. These, along with infant mortality, are significant contributors to the life expectancy gap, as they are to overall life expectancy. It shows that respiratory diseases make a greater contribution to the mortality gap for females compared to males, and external causes of death only affect the male mortality gap. External causes include accidents, fires, assault, intentional self-harm and complications of medical and surgical care.

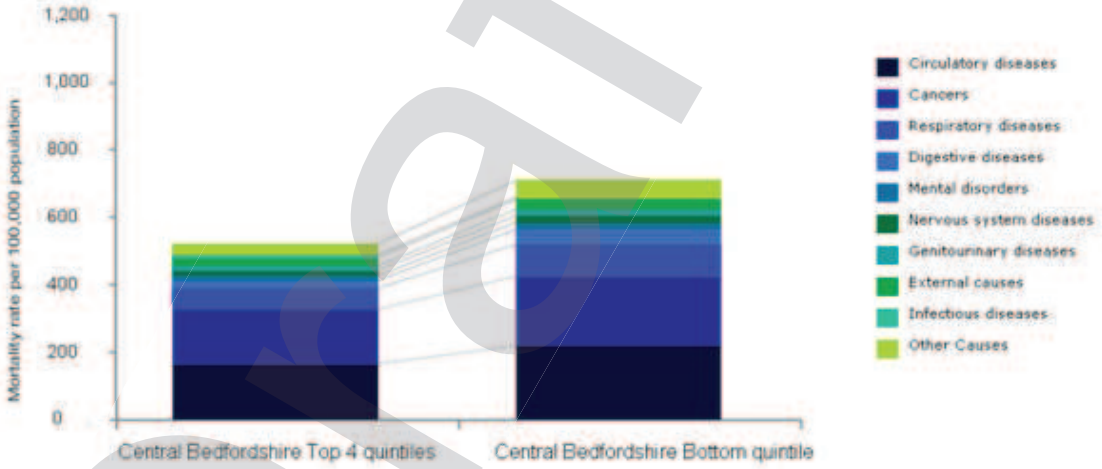
Figure 4: Leading causes of the mortality gap between the 80% least deprived and 20% most deprived areas in Central Bedfordshire, 2005-09 combined



Data source: http://www.sepho.nhs.uk/gap/gap_national.html

Figure 5 shows the absolute gap in mortality between the most deprived 20% and the least deprived 80% for males and females combined. It shows how much higher the mortality rate is in the most deprived 20% for the main causes of mortality.

Figure 5: Cause specific mortality for Central Bedfordshire persons - top 4 quintiles (80%) of deprivation and bottom quintile (20%), 2005 to 2009 combined.



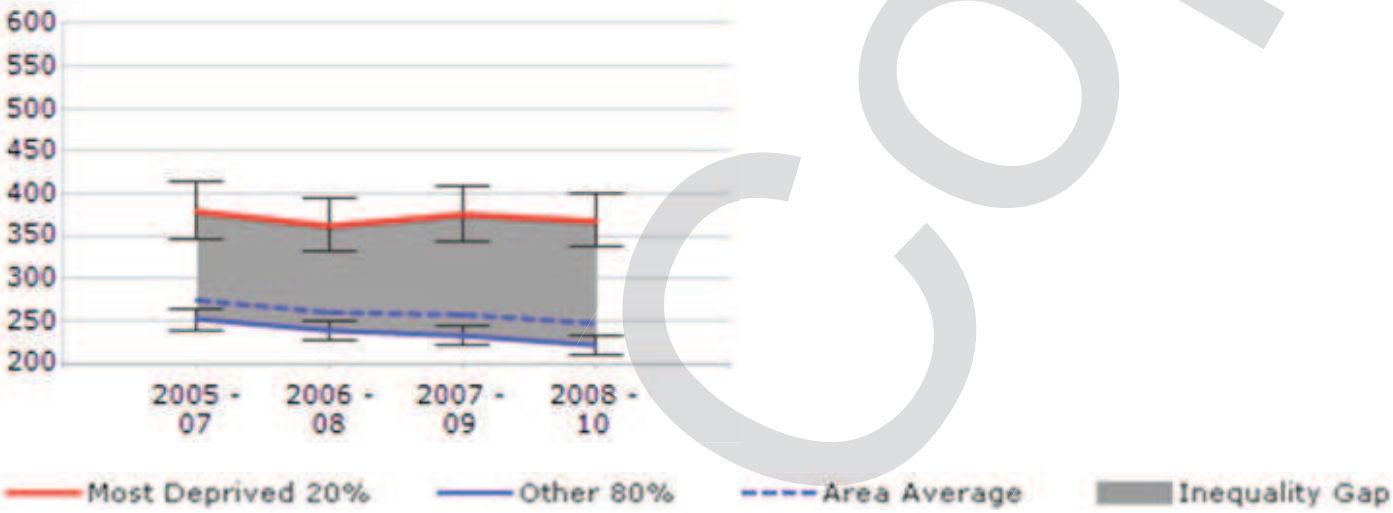
Source: http://www.sepho.nhs.uk/gap/gap_national.html

3.3 Inequalities in premature mortality

Premature mortality, defined as deaths under the age of 75 years, has a large impact on life expectancy. The inequalities in premature mortality rates for the 3 biggest killers (circulatory diseases, cancer and respiratory diseases) are described below.

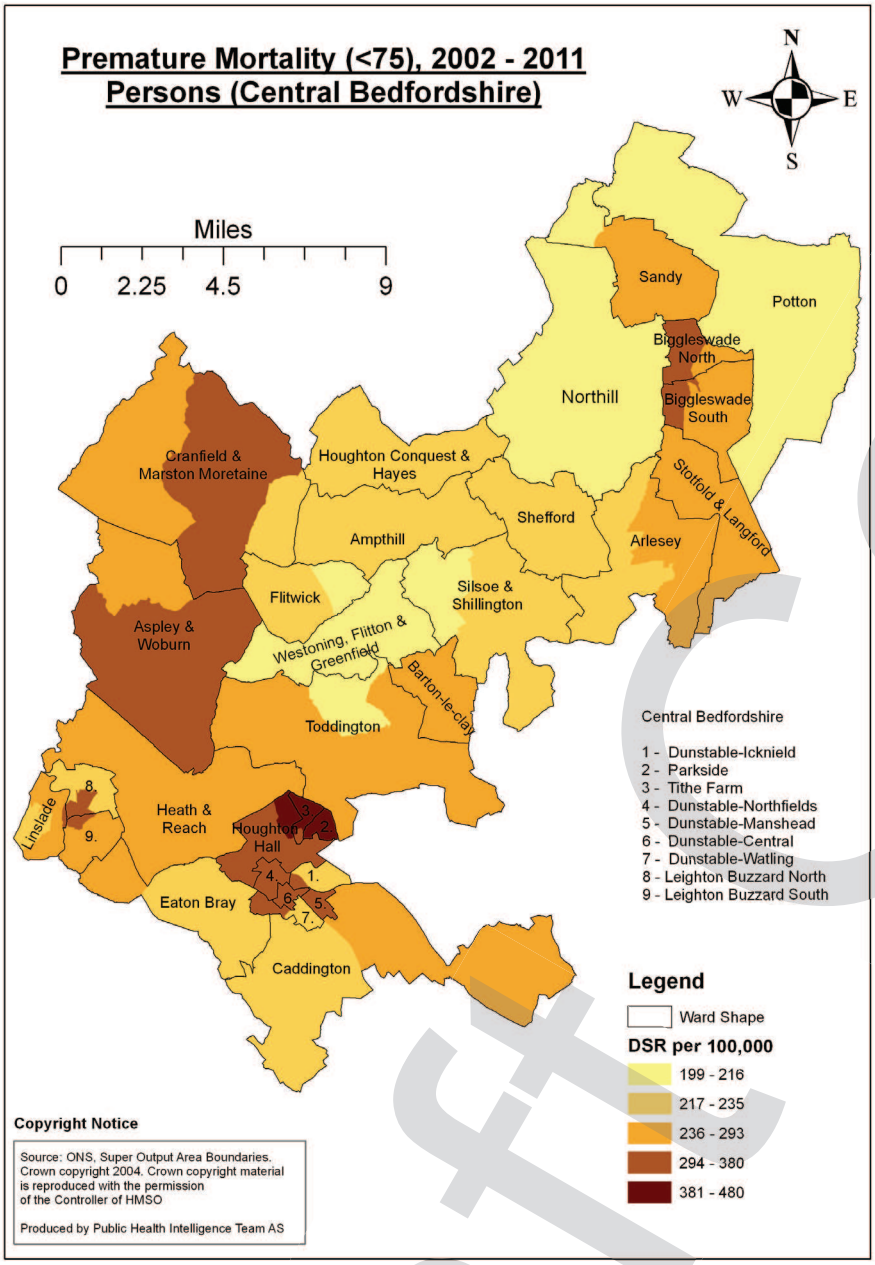
Figure 6 shows the mortality from all causes for people aged below 75 years. For both males and females, there is a statistically significant and growing premature mortality gap between the most deprived 20% and the least deprived 80%. The gap is growing because the mortality rate in the least deprived 80% is decreasing whereas in the most deprived 20% it is not improving.

Figure 6: Trends in all cause mortality per 100,000 among people aged below 75 years in Central Bedfordshire persons



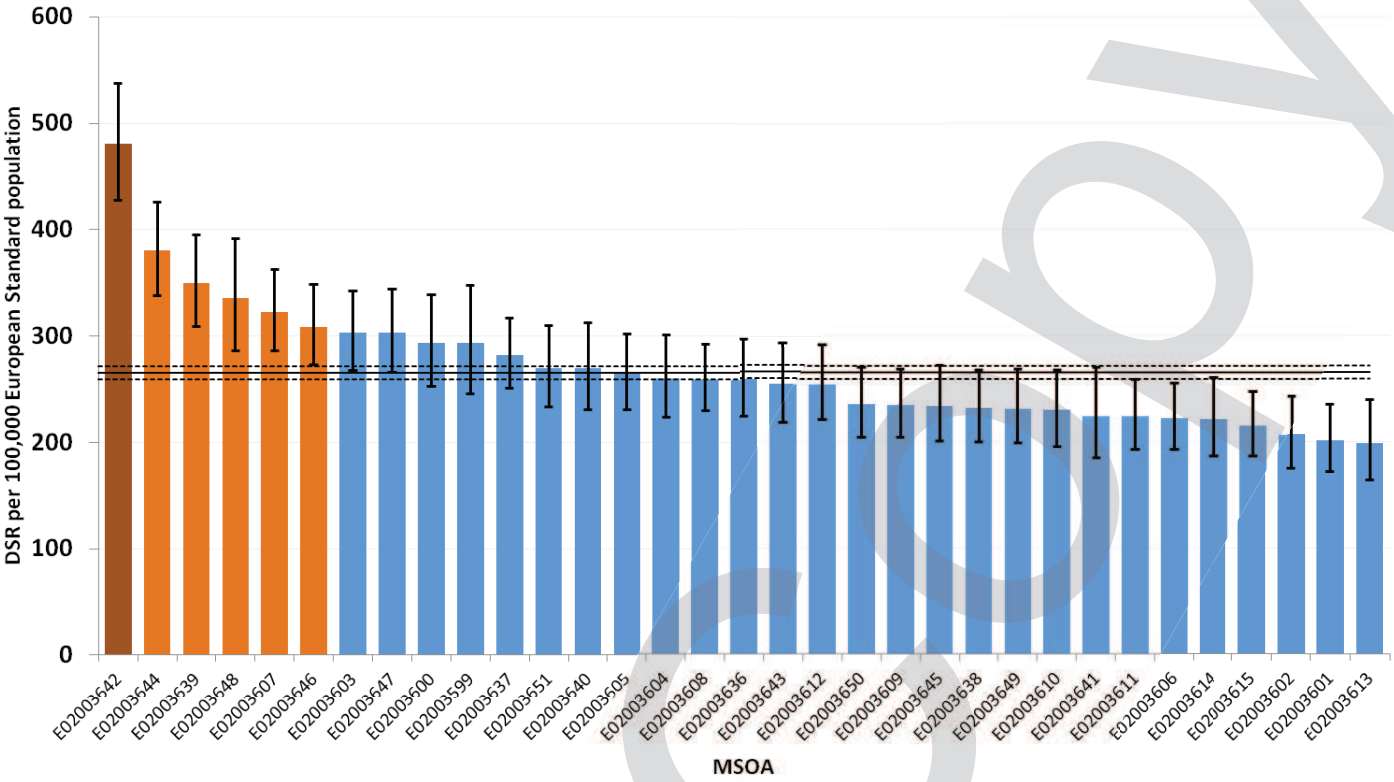
Mapping premature mortality demonstrates that the risk of dying early in Central Bedfordshire follows a similar pattern to deprivation. In figure 6a, the darkest coloured areas are those where premature mortality is highest; comparing this to figure 2 (page 9) shows that many of the areas worst affected are also those with high deprivation scores. Ten years' worth of data from 2002 to 2011 has been used to smooth out year-to-year variation and generate a more reliable pattern. One area that goes against the general pattern covers Marston Moretaine, Woburn. This area has average deprivation but above average premature mortality, this should be investigated to rule out any systematic issues.

Figure 6a: Premature mortality rates by middle-layer super output area, Central Bedfordshire, 2002-2011, directly standardised by age.



The variation between the different areas of Central Bedfordshire is shown in figure 6b. The data are grouped by MSOAs, which do not cover the same geography as electoral wards but in most cases approximate quite closely to ward boundaries. The highest rate of premature mortality (in the area of Tithe Farm and Parkside wards) is 2.4 times greater than the lowest rate (in the eastern portion of Flitwick). The six bars coloured brown represent areas which suffer premature mortality rates that are significantly higher than the Central Bedfordshire average: from left to right they match the areas on the map as follows: Tithe Farm/Parkside, Houghton Hall, Leighton Buzzard, Dunstable Manshead, the large area crossing Cranfield & Marston Moretaine and Aspley & Woburn wards, and Dunstable Northfields.

Figure 6b: Premature mortality rates by middle-layer super output area, Central Bedfordshire, 2002-2011.

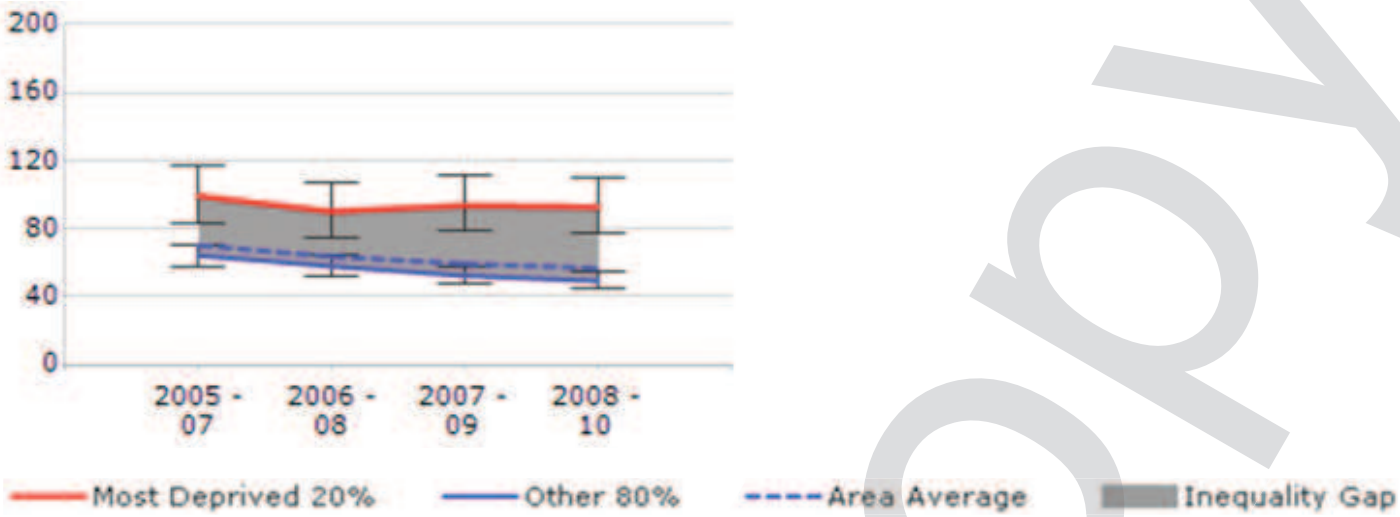


3.4 Circulatory disease inequalities

Cardiovascular disease (CVD) is the collective term for a group of related conditions affecting the heart, arteries or blood vessels. It includes coronary heart disease and stroke which account for about 50% and 25% of these conditions respectively.

As shown in Figures 4 and 5 in the previous section, cardiovascular disease is the single largest driver of increased mortality in the 20% most deprived compared to the 80% least deprived. Figure 7 below, shows that there is a widening gap in premature mortality due to CVD (as the confidence intervals do not overlap the difference is statistically significant). This gap is widening because the rate in the most deprived 20% has changed very little, but the rest of the population shows a steady decrease.

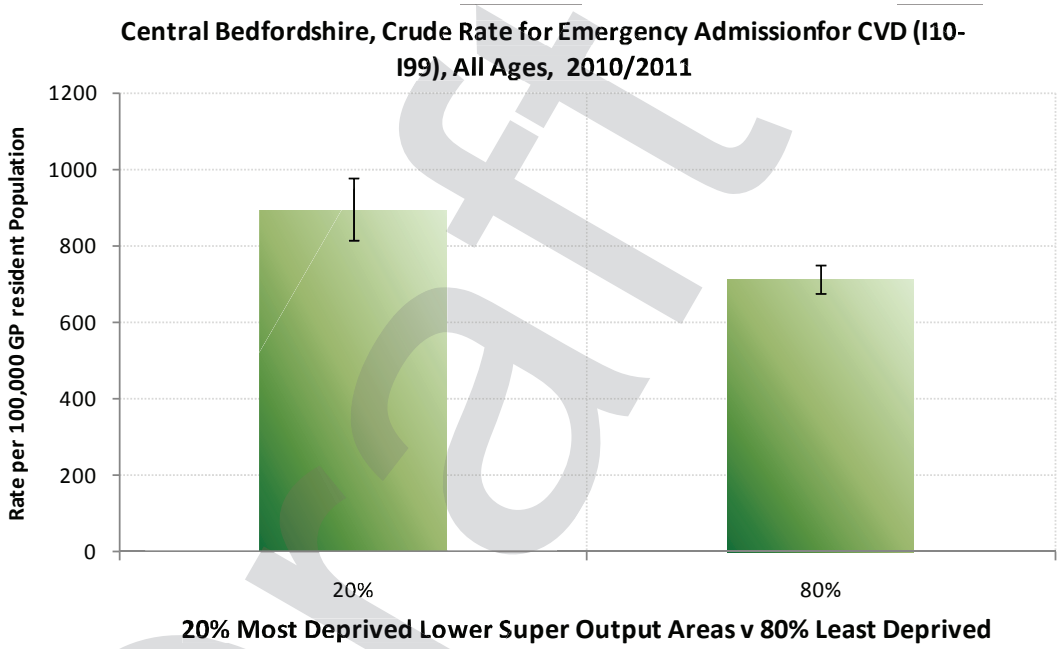
Figure 7: Trends in cardiovascular disease mortality per 100,000 among people aged below 75 years in Central Bedfordshire



Source: ERPHO fingertips: http://fingertips.erpho.org.uk/

Higher rates of cardiovascular disease in the most deprived areas leads to higher rates of emergency admissions as shown in figure 8. Within CVD, significantly higher rates of emergency admissions are also seen from the deprived 20% for coronary heart disease (1.4 times greater) and heart failure (1.7 times greater) but not for cerebrovascular disease, which includes stroke.

Figure 8: Emergency admission crude rates for cardiovascular disease 20% most deprived and 80% least deprived in Central Bedfordshire



Source: NHS Bedfordshire

Key Actions

The Care Quality Commission report of 2009[8] acknowledges that up to 90% of the risk of a first heart attack is due to lifestyle factors that can be changed. There are effective interventions that can reduce risk, prevalence and deaths from CVD. In addition to medical interventions, people making healthier choices, such as eating healthier foods, using alcohol in moderation, undertaking regular physical activity, stopping smoking, reducing obesity and promptly accessing services can reduce the risk and deaths from CVD.

We need to ensure that the NHS Health Checks programme, which identifies those aged 40 – 74 at greatest risk of a cardiovascular event (e.g. heart attack, stroke, etc.), is taken up by those from deprived areas. We also need to monitor that those identified at greatest risk adopt lifestyle and other changes to reduce their risk.

Revascularisation rates for persons who live in the most deprived areas of Bedfordshire are 1.7 times greater than those who live in the least deprived areas, thus suggesting that medical care is provided more to those with greater need.

'NSF standard five: Stroke' recommends taking action to reduce the incidence of stroke in the population, and ensure that those who have had a stroke have prompt access to integrated stroke care services. It sets out four main components for the development of integrated stroke services:

- Prevention: including the identification, treatment and follow-up of those at risk of stroke.
- Immediate care: including care from a specialist stroke team.
- Early and continuing rehabilitation.
- Long-term support for the stroke patient and their carers.

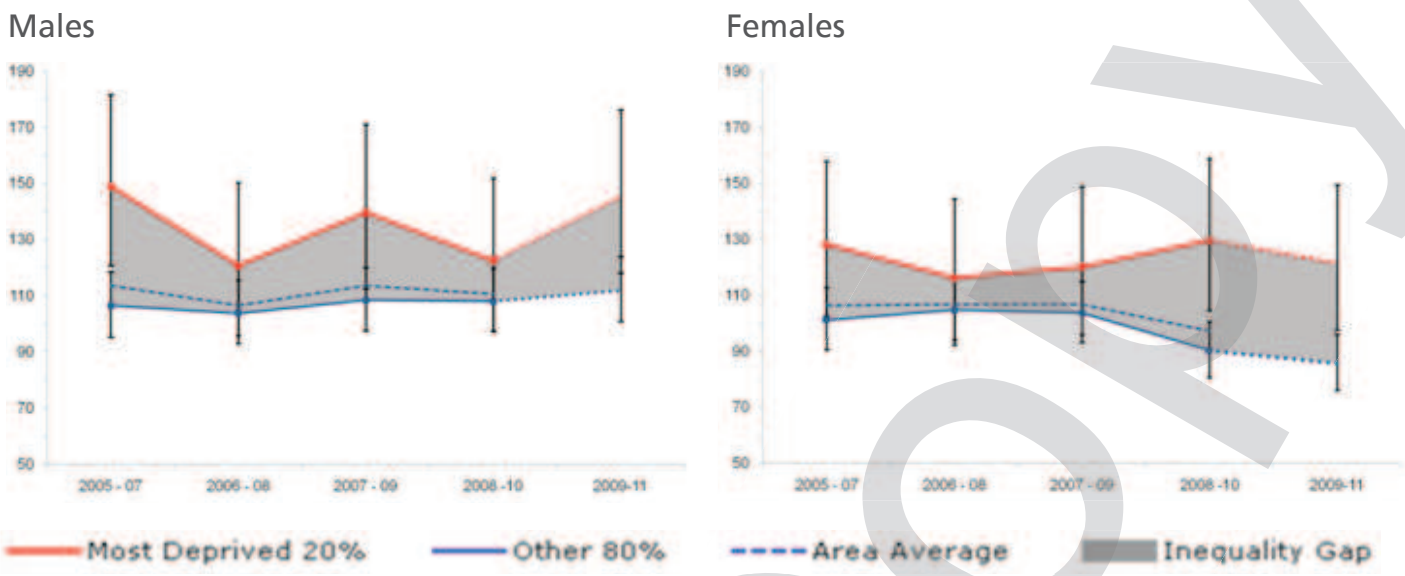
3.5 Cancer inequalities

Overall, cancer is the second biggest cause of the life expectancy gap between the most deprived 20% and the other 80%. It is also the largest cause of premature mortality in Central Bedfordshire, accounting for around 41% of deaths before the age of 75 years. Premature mortality from cancer has declined in Central Bedfordshire by about 20% in the last 10 years.

Figure 9 shows the cancer mortality trends using 3-year pooled data for 2005-07 to 2008-10 for males and females aged below 75 years in Central Bedfordshire. The gap for males has been decreasing and is now no longer significant, mostly due to decreasing rates in the more deprived areas. However, for females the gap widened between 2006-08 and 2008-10 due to both increasing rates in the most deprived 20% and decreasing rates in the least deprived 80%. The combined figures (i.e. for persons under 75) shows that, apart from 2006-08, there has been a statistically significant gap in the mortality rates between the 20% most deprived and the least deprived 80%. This gap shows no discernible trend.

8 Care Quality Commission, 2009. Closing the gap Tackling cardiovascular disease and health inequalities by prescribing statins and stop smoking services.
URL: http://archive.cqc.org.uk/_db/_documents/Closing_the_gap.pdf

Figure 9: Trends in cancer mortality DSR per 100,000 among people aged below 75 years in Central Bedfordshire



Data source: 2005 – 2010 ERPHO fingertips: http://fingertips.erpho.org.uk/ and 2009-11 NHS Bedfordshire (provisional figures)

For mortality under 75 the most common cancers, accounting for about half of all cancers, are:

- **Males:** Lung (21%), Colorectal (10%), Oesophageal (9%) and Prostate (8%)
- **Females:** Breast (24%), Lung (15%) and Colorectal (10%)

For all age mortality the order changes somewhat, the main cancers are:

- **Men:** Prostrate (26%), Colorectal (16%) and Lung (12%)
- **Women:** Breast (36%); Colorectal (11%) and Lung (10%)

Key actions

By far the largest preventable risk factor for cancer is smoking. Excess weight, unhealthy diets and alcohol together with smoking causes about one third of cancer diagnoses in the UK each year[9].

Early diagnosis is important in improving survival and preventing avoidable deaths. This is supported through good public awareness of signs and symptoms of cancers and good screening programmes.

9 DM Parkin (2011). The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010.British Journal of Cancer, 105 (Supplement 2)

Key actions to reduce premature mortality from cancer in Central Bedfordshire include:

- Increasing awareness of symptoms - The National Awareness and Early Diagnosis programme has shown some promising results and should be continued and expanded.
- Continued emphasis on the delivery of an effective Stop Smoking Service, particularly in more deprived areas.
- Close working with Anglia and Mount Vernon cancer networks to improve outcomes for Central Bedfordshire residents.
- Increasing uptake of cancer screening programmes, particularly bowel cancer screening, through health promotion activities - starting with the GP practices where there is low uptake of the programme.

3.6 Chronic respiratory disease inequalities

Chronic respiratory diseases are the third biggest contributor to the inequalities gap in mortality in Central Bedfordshire. Premature mortality from respiratory disease in Central Bedfordshire (11.1 per 100,000 people) is statistically significantly higher than the east of England (8.9).

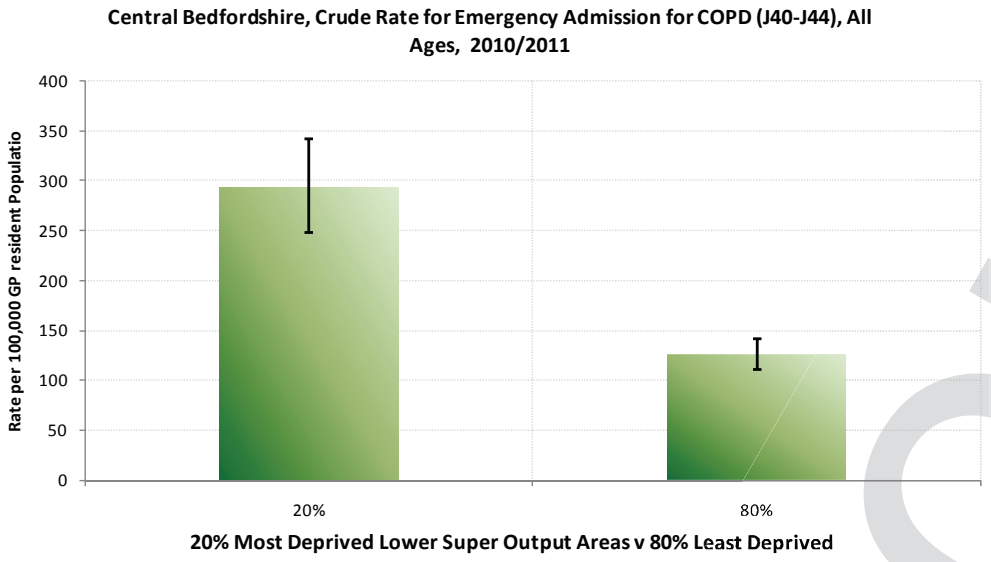
There is virtually no gap in premature mortality for females, but there is a growing gap for males, as shown in figure 10. For males, premature mortality is now three times as high in the most deprived 20% as in the other 80%.

Figure 10: Trends in chronic respiratory disease mortality per 100,000 among males aged below 75 years in Central Bedfordshire

Source: ERPHO fingertips: http://fingertips.erpho.org.uk/

Figure 11 shows that the emergency admission rate for chronic respiratory disease is 2.3 times greater in the most deprived 20% than the rate for persons who live in the least deprived 80% of Central Bedfordshire.

Figure 11: Emergency admissions for chronic respiratory disease per 100,000 population, all ages in Central Bedfordshire



Source: NHS Bedfordshire

Key Actions

The majority of chronic respiratory diseases are due to smoking, so reducing rates of smoking in the most deprived areas is vital.

Early diagnosis through improved awareness of symptoms amongst those who live in deprived areas, followed by good control of symptoms, improves quality and length of life.

4 Lifestyles and health inequalities

Many interconnected factors lead to health inequalities. It is clear that lifestyle factors such as smoking, poor diet, inactivity and excessive alcohol consumption all play their part in determining poor health. On average people with all four of these unhealthy behaviours die 14 years earlier than those with none. However these lifestyle factors are not adopted by deliberate choice but are often the result of living in a family or community where these lifestyles are prevalent and considered normal.

4.1 Smoking

Smoking increases the risk of developing many diseases including cardiovascular diseases, cancers, and chronic respiratory diseases. Smoking is the single, biggest cause of inequality in death rates between the rich and the poor in the UK. Smoking accounts for over half of the difference in risk of premature death between the least and most well off.[10]

Since the health dangers of smoking have become well known, rates of smoking have declined significantly - more amongst the most well off than those who are more deprived.

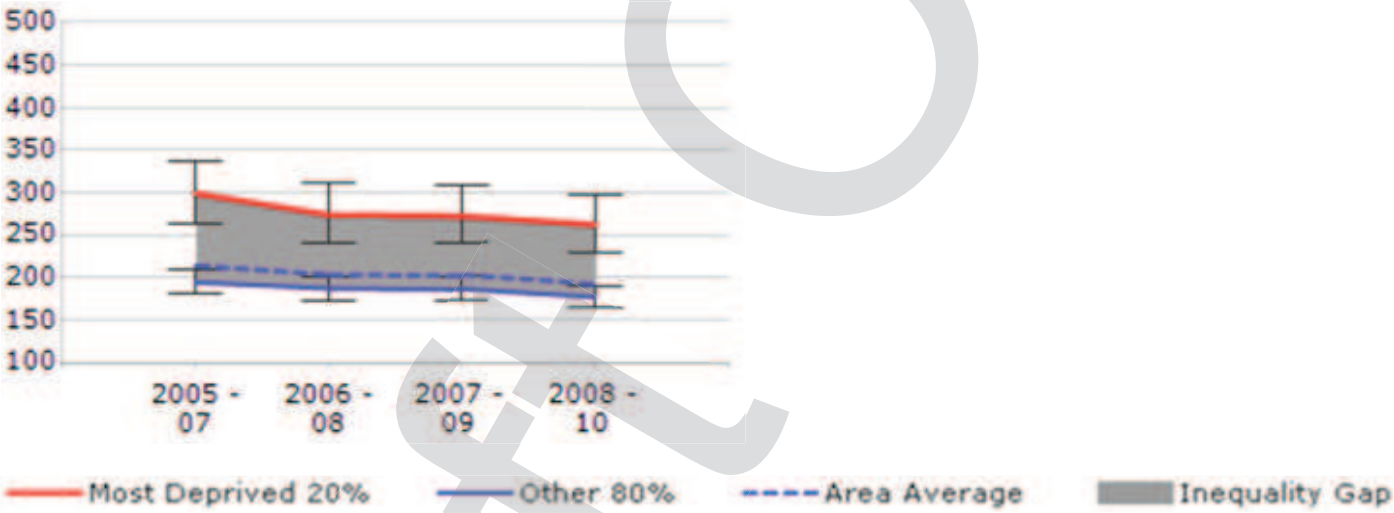
10 ASH, Smoking and Health Inequalities, 2011

In 2011, the prevalence of smoking among adults in Central Bedfordshire was 16.7%, lower than the east of England average of 19.8% (ERPHO Fingertips[11]). The smoking prevalence in the more deprived areas of Central Bedfordshire is not known. A telephone survey[12] in 2008 indicated that the smoking prevalence in the most deprived 20% of MSOAs in the whole of Bedfordshire[13] was 22.2% (CI 18.6% - 22.6%) compared to 15.8% (CI 13.3% - 18.7%) in the least deprived 80%.

The Integrated Household Survey[14] carried out between October 2010 and September 2011 showed that 25.1% of routine and manual adults in Central Bedfordshire were smokers. Although not all 'routine and manual' people will live in the more deprived areas, this does confirm higher rates of smoking among the less well-off.

Based on studies comparing smokers and non-smokers, mortality can be attributed to smoking. For example, 90% of lung cancers are due to smoking. Smoking attributable mortality is declining in both the most deprived and the rest of the population at about the same rate, as shown in figure 12. However, there is still a significant gap between the 20% most deprived and the least deprived 80%.

Figure 12: Trends of smoking attributable mortality per 100,000 in Central Bedfordshire persons



Source: ERPHO fingertips: http://fingertips.erpho.org.uk/

11 ERPHO Fingertips. http://fingertips.erpho.org.uk/, exact period 2010/11 Q3 – 2011/12 Q2
12 Erpho Revised 2008 Lifestyle Survey summary: Bedfordshire PCT.
13 Bedfordshire here means the 2 Unitary Authorities of Central Bedfordshire and Bedford Borough.
14 Integrated Household Survey, ONS, published by London Health Observatory www.lho.org.uk.

Key actions

In 2011/12 31.0% of quitters came from the 20% most deprived LSOAs in Central Bedfordshire, this is just sufficient to prevent the widening of inequalities. The targets for 2012/13 have been calculated for Central Bedfordshire to ensure at least 30% of quitters are from the 20% most deprived MSOAs. Work should continue to get a higher proportion of smoking quitters from the most deprived areas by:

- Targeting women from deprived areas who smoke during pregnancy.
- Working with schools whose pupils come from the most deprived areas to support young people to stop smoking or not to start in the first place.
- Targeting those from lower social classes by offering support through the workplace.
- Working with trading standards to reduce under age sales of cigarettes in areas where rates are highest amongst young smokers.
- Increasing the provision and ease of access to stop smoking services in deprived areas e.g. through clinics in neighbourhood centres.
- Providing increased support to GPs serving deprived areas to meet targets.

4.2 Adult obesity

Conditions linked with obesity (and the associated lifestyle choices) include: cardiovascular disease; respiratory conditions; insulin resistance and type 2 diabetes; certain cancers; musculoskeletal problems; low self esteem and depression. There is an exponential rise in risk as obesity levels increase. As a result, development of obesity in middle age shortens life expectancy on average by 2-4 years, or by 8-10 years in those who become morbidly obese[15].

The prevalence of obese adults in Central Bedfordshire is estimated to be 24.2%, similar to the east of England average (ERPHO Fingertips[16]). It is estimated that in Central Bedfordshire there are over 8,800 people with high blood pressure, nearly 4,100 people with cardio-vascular diseases and around 2,800 people with diabetes because they are obese[17].

While everyone is susceptible to obesity, levels are disproportionally higher in the lower socio-demographic, socially disadvantaged groups and some ethnic groups. A greater proportion of men are overweight than women but approximately three times as many women as men are severely obese (BMI equal to or greater than 40). In both men and women BMI generally increases with age.

Key actions

- Ensure Central Bedfordshire workplaces are exemplars of healthy working environments.
- Deliver social marketing interventions to influence positive health behaviour in target geographical locations.
- Promote brief intervention advice for healthy living throughout the patient journey such as Making Every Contact Count (MECC).
- Actively consider opportunities for active travel on all future planning requests.
- Engage business through the Governments Food and Nutrition and Physical Activity Responsibility Deal partnerships.
- Ensure that opportunities for increasing physical activity are maximised e.g. leisure facilities and the built environment.

15 Observatory NO. Briefing note: Obesity and life expectancy. Oxford, UK: NOO; 2010.
16 Erpho Fingertips. http://fingertips.erpho.org.uk/
17 Central Bedfordshire Joint Strategic Needs Assessment.

4.3 Alcohol

The impact of alcohol misuse is widespread; encompassing alcohol related illness and injuries, as well as significant social impacts including crime and violence, teenage pregnancy, loss of work place productivity and homelessness.

The impact of alcohol on health, social status and safety can affect everyone. Generally, as income rises, so does alcohol consumption. The proportion of people exceeding the sensible drinking guidelines also rises as income rises. People with lower socio economic status are more likely to abstain altogether. If they do consume alcohol, they are more likely to have problematic drinking patterns and dependence than people higher up the social scale.

Higher admission rates for alcohol specific conditions for both males and females are also associated with higher levels of deprivation.

Projections of the number of people predicted to have an alcohol problem in Central Bedfordshire are shown in table 2.

Table 2: People aged 18-64 predicted to have an alcohol problem by gender projected to 2025 in Central Bedfordshire

	2012	2015	2020	2025	2030
Males	7,151	7,308	7,586	7,830	7,995
Females	2,716	2,762	2,871	2,957	3,000
Total population predicted to have alcohol dependence	**9,867**	**10,070**	**10,457**	**10,787**	**10,995**

Source: Projecting Adult Needs and Service Information (www.pansi.org.uk/)

Key actions

To tackle issues and problems associated with alcohol use, the Joint Needs Strategic Assessment (JSNA) has proposed the following actions:

Children and Young People

- Deliver universal alcohol education in all middle and upper schools, particularly targeting those schools serving the more deprived areas.
- Enhance early intervention services for young people, particularly: those who have offended; Looked after Children; those who are not in education, employment or training (NEET); those in contact with Social Care Services and those aged 14 and under.
- Enhance services for families and in particular work with parents, children and young people affected by substance misuse issues.
- Improve the interface between Tier 2 & Tier 3 services for children and young people and their families affected by substance misuse issues.

Adults and older people

- Continue delivery of the Alcohol Identification and Brief Advice (IBA) training, ensuring that IBA is routinely provided by frontline agencies/services.
- Highlight the changing drinking patterns of older people and women through the delivery of IBA, Making Every Contact Count (MECC) and the monthly alcohol campaign.
- Provide a greater focus on the effects of problematic home drinking, preloading and habitual drinking.
- Effectively commission high quality alcohol prevention and treatment services.

5 Health inequalities affecting babies, children and young people

Central to the Marmot Review is the recognition that disadvantage starts before birth and accumulates throughout life. Thus, the highest priority is attached to the first objective: giving every child the best start in life.

5.1 Low birth weight

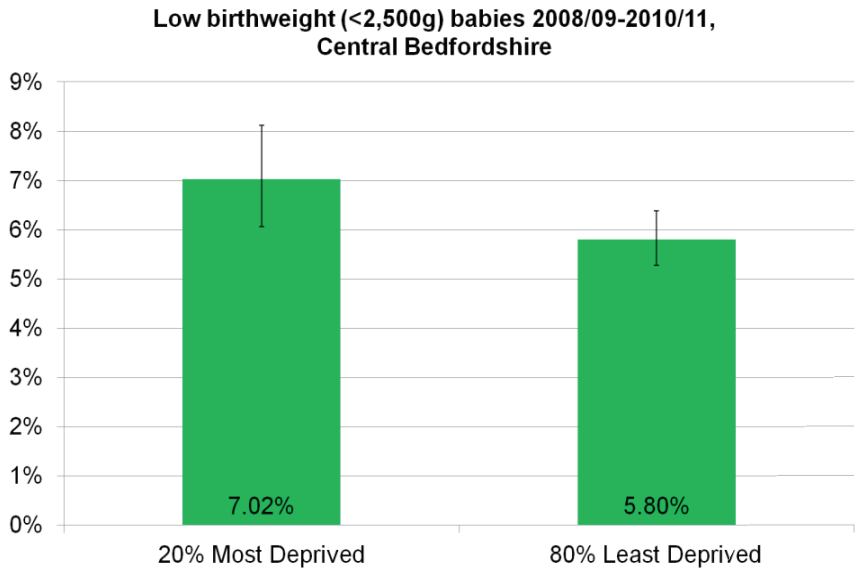
Low birth weight is defined as a weight of less than 2500g; a subset of this is very low birth weight (less than 1500g). At the population level, the proportion of babies with a low birth weight is an indicator of a multifaceted public-health problem that includes long-term maternal malnutrition, ill health, hard work and poor health care in pregnancy[18].

On an individual basis, low birth weight indicates that the pregnancy was not optimal; that growth in the womb was restricted; and that the baby's organs, including its heart, kidney and bone, are permanently changed. This leads to an increased risk of infant mortality, poor infant health and poor adult health. Low birth weight has been correlated with coronary heart disease, stroke, cancer, diabetes and osteoporosis in later life and reduced life expectancy[19].

Figure 13 shows that the percentage of low birth weight babies in the most deprived 20% of LSOAs is 21% higher than in the 80% least deprived. Although this is not statistically significant (as the confidence intervals overlap in the chart below), it is important to continue to monitor the situation to ensure the gap does not widen further. Very low birth weight births (under 1,500 grams) are 57% more common in the most deprived 20%, but again this is not statistically significant.

18 http://www.who.int/whosis/indicators/compendium/2008/2bwn/en/index.html
19 www.thebarkerfoundation.org

Figure 13: Inequalities in low birth weight in Central Bedfordshire



Source of data: Office for National Statistics

Key actions

Nutrition of girls and young women

In England, even though there is very little calorie malnutrition, many babies remain poorly nourished in the womb because their mothers eat diets that are unbalanced in macronutrients (protein, fats and carbohydrates) and deficient in micronutrients (including vitamins and minerals)[20].

Fundamental to increasing birth weights is improving the nutrition of girls and women of child bearing age. Ideally they should be well nourished throughout life, not just when they become pregnant, to ensure their bodies have reserves to pass on to their baby.

Intensive antenatal visits (as recommended in the Marmot Report) by a health visitor or midwife for women who live in deprived areas should occur as early as possible in pregnancy. This should include nutritional advice as well as advice and support to stop smoking if required (see below). This should be monitored by those commissioning the 0-5 years Healthy Child Programme.

5.2 Stopping Smoking in pregnancy

Stopping smoking in pregnancy is one of the most effective steps a woman can take to improve her health and the health of her baby. Many of the 4,000 chemicals in tobacco smoke can cross the placental barrier and have a direct toxic effect on the foetus. Maternal smoking can cause major morbidity and mortality to the foetus and new born baby, including:

- 32% increase in miscarriage and 26% increased risk of perinatal death.
- 1.5 to 2.5 fold increased risk of low birth weight babies.
- 27% increased risk or a preterm birth (before the 37th week of pregnancy). Preterm birth is a major cause of infant mortality and can affect physical and mental development during childhood.

20 www.thebarkerfoundation.org

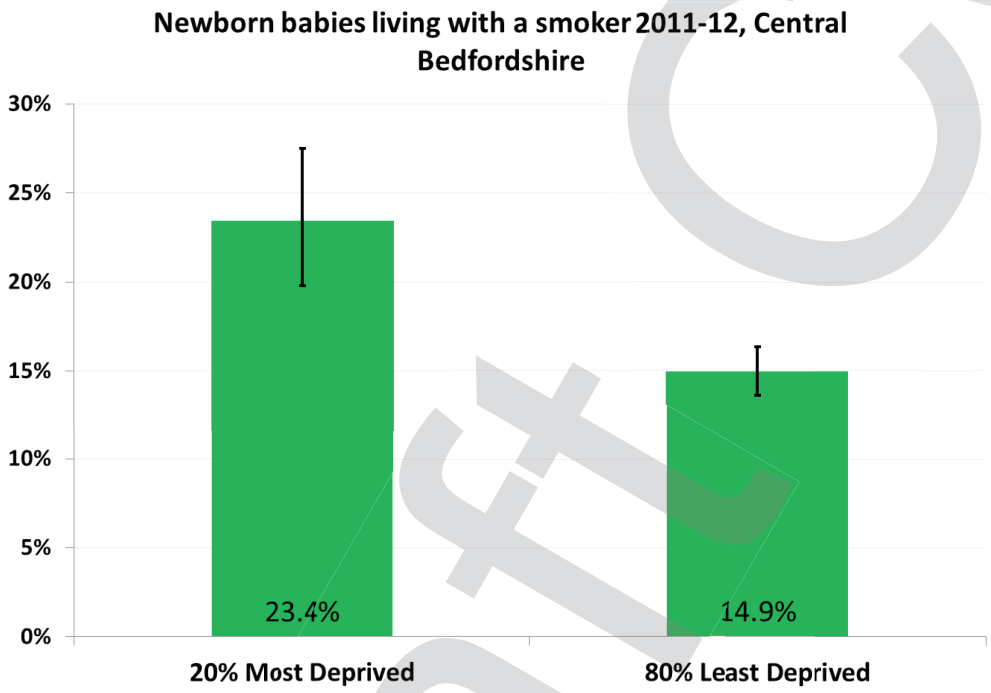
Data are available for hospital trusts for all NHS Bedfordshire patients but not at unitary authority level. These show that smoking rates have been consistently higher in the Luton and Dunstable Hospital (above 20%) compared to Bedford Hospital (just over 10%), indicating higher smoking rates in pregnancy in the south of Central Bedfordshire.

Babies living with a smoker

This can be used as a proxy for smoking during pregnancy. Compared to smoking in pregnancy, more details are available on babies living with a smoker in the household, whether the smoker is the mother or another member of the household. These babies suffer the harm caused by second hand smoke, and if the smoker is also their mother they will have suffered the harms listed above whilst in the womb.

Figure 14 shows the proportion of new born babies living with a smoker in Central Bedfordshire. In 2011/12, 23.4% of babies from the 20% most deprived LSOAs lived in a household with at least 1 smoker, compared to 14.9% in 80% least deprived LSOAs; a statistically significant gap.

Figure 14: Proportion of new-born babies living with a smoker in Central Bedfordshire



Data source: SystmOne, South East Essex Partnership Trust (SEPT)

Key actions

There is a need to continue to reduce the rates of smoking prevalence, with an emphasis on those from the most vulnerable communities, where the rates are highest - specifically targeting pregnant women and individuals sharing a house with a baby or young child. This can be done by:

- Increasing access to stop smoking services for women from deprived areas who smoke during pregnancy.
- Continuing to provide Level 1 and Level 2 stop smoking training to midwives and health visiting teams.

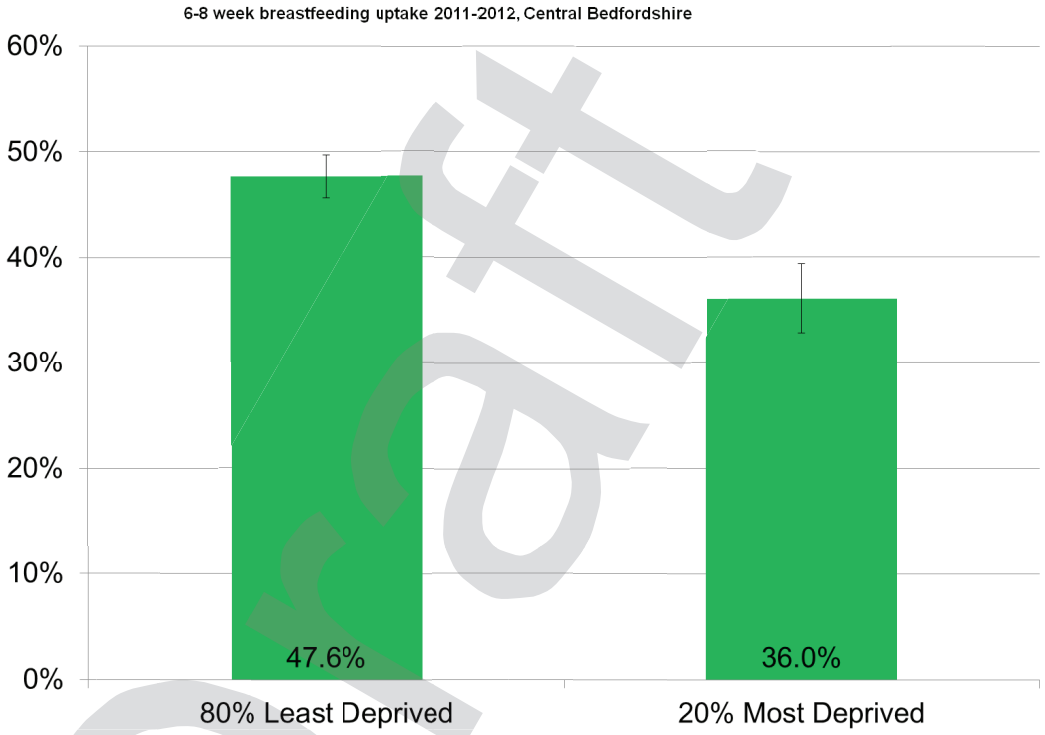
- Continuing to provide home based appointments with the Stop Smoking Service to improve access by mothers with young children.
- Supporting the reduction of smoking prevalence including partners and families and to improve outcomes for parents and their children by expanding the Smokefree homes and cars programme
- Extending partnership working to encompass smoking in pregnancy and second-hand smoke
- Analysing existing data to identify communities with high rates of smoking amongst mothers to enable targeting of future stop smoking campaigns.

5.3 Breastfeeding

Building on a healthy pregnancy, breastfeeding helps secure the best start in life for new-born infants. It promotes health and prevents disease in both the short and long term for both infant and mother. Infants who are not breastfed appear more likely to suffer with conditions such as gastroenteritis and respiratory disease requiring hospitalisation. Breastfeeding reduces the risk of high blood pressure and raised blood cholesterol in adulthood and may reduce the risk of type 2 diabetes and obesity. Breastfeeding is also associated with a reduction in the risk of breast and ovarian cancers for mothers (DH, 2009).

Figure 15 shows the 6-8 weeks breastfeeding uptake in Central Bedfordshire. In 2011/12 the breastfeeding rate at 6-8 weeks was 36.0% in the 20% most deprived LSOAs and was 47.6% in the 80% least deprived; a statistically significant difference. The rate in Tithe Farm, the most deprived ward in Central Bedfordshire, doubled from 16.7% in 2010/11 to 32.8% in 2011/12, thanks to the targeted work described below.

Figure 15: 6-8 weeks breastfeeding uptake in Central Bedfordshire



Data source: SystmOne, South East Essex Partnership Trust (SEPT)

The majority of the deprived LSOAs lie in the south of Central Bedfordshire and the women are most likely to have delivered at Luton and Dunstable Hospital, which has a relatively poor record at initiating breastfeeding.

Key actions

Evidence shows that Baby Friendly accreditation can add 10% to breastfeeding rates (UNICEF, 2011). Both Bedford Hospital and Luton and Dunstable Hospital have achieved Stage 1 Baby Friendly Accreditation. The Community Health Services and eight Children's Centres, including those in Tithe Farm, Dunstable and Parkside, have been awarded Stage 2 Baby Friendly accreditation. Plans are under way for the 0-19 team to achieve Baby Friendly accreditation at level 3 next year.

Baby Brasseries located in Children's Centres across Central Bedfordshire offer encouragement to pregnant women to consider the benefits of breastfeeding and support to new mothers to help them practically with breastfeeding. The Tithe Farm Children's Centre has a Baby Brasserie, which may account for the improved breastfeeding rates recently seen in the area.

Other actions include:

- Continuing to raise awareness of the benefits of breastfeeding and remove barriers antenatally, through intensive antenatal visits.
- Continuing to train peer supporters.
- Encouraging a positive culture of breastfeeding in deprived areas, including through development of local community champions and extension of the 'Out and About' award to accredit breastfeeding-friendly eating establishments.
- Improving monitoring of the use of Children's Centres to help determine whether particular groups of women are not accessing the programmes so that specific support can be given.

5.4 Childhood obesity

The emotional and psychological effects of being overweight are often seen as the most immediate and most serious problems by children themselves. They can include: teasing and discrimination by peers; low self-esteem; anxiety and depression.[21]

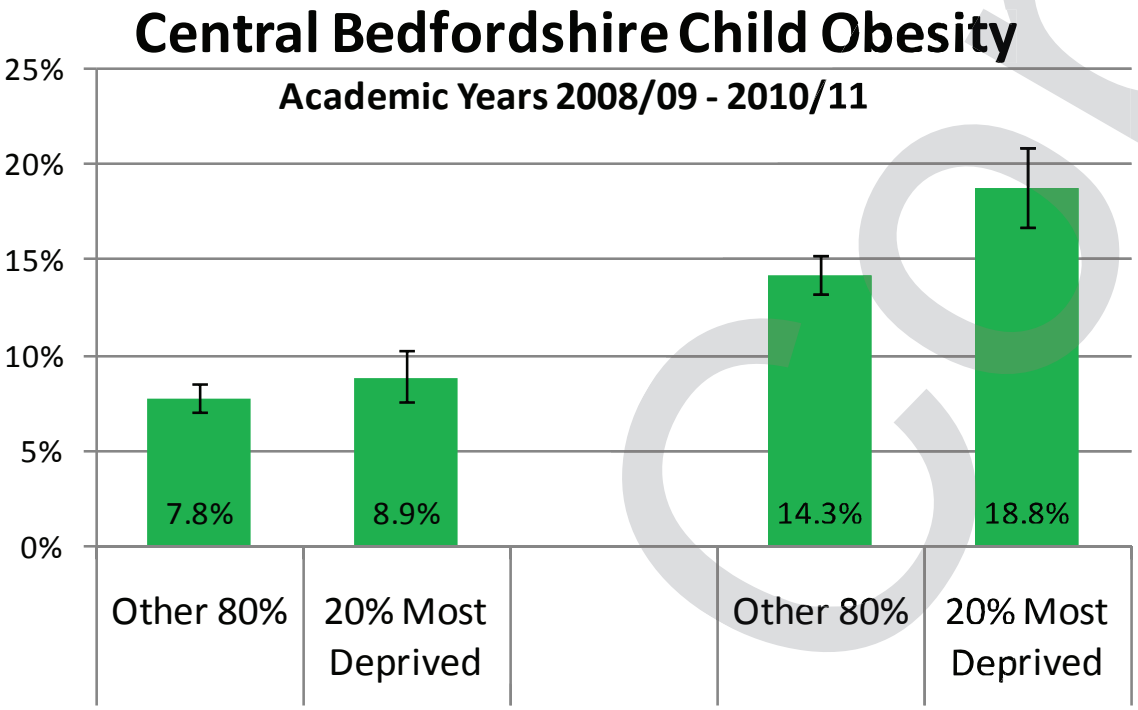
Obese children may also suffer disturbed sleep and fatigue. Some obesity-related conditions can develop during childhood. Type-2 diabetes, previously considered an adult disease, is beginning to be seen in obese children as young as five. Some musculoskeletal disorders are also more common. Overweight and obese children are more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. Above average BMI at age 5 and older is a risk factor for development of type-2 diabetes later in life. Below average BMI at age 5 combined with above average BMI at age 11 creates increased likelihood of coronary heart disease as an adult (Barker, 2007[22]).

21 Schwimmer, J.B., Burwinkle, T.M and Varni, J.W. (2003) Health-Related Quality of Life of Severely Obese Children and Adolescents. JAMA 289: 1813-1819

22 Obesity and early life, D. J. P. Barker, obesity reviews (2007) 8 (Suppl. 1), 45–49

Children's heights and weights are monitored through the National Child Measurement Programme (NCMP), for which there is very good participation in Central Bedfordshire. Figure 16 shows the prevalence of childhood obesity in Central Bedfordshire; higher rates of obesity are seen in the 20% most deprived areas compared to the 80% least deprived. This is not statistically significant in the Reception Year (Year R, age 4-5) but it is in Year 6 (age 10-11).

Figure 16: Prevalence of childhood obesity in Central Bedfordshire



Source: NHS Bedfordshire

Locally there are insufficient data to comment on inequalities in childhood obesity due to ethnicity.[23]

Key actions

Apart from improving the health of mothers-to-be and infants as described in sections 5.1 and 5.2, various actions can be taken. These include:

- Improving access to high quality and affordable food in deprived areas.
- Improving access to open play areas and use of active transport e.g. by making these safe options in deprived areas.
- Supporting play programmes and other physical activity schemes in deprived areas.
- Ensuring that school staff, GPS and health visitors working in deprived areas are trained to discuss overweight and obesity, offer brief intervention advice and signpost to services.
- Educating parents to recognise childhood obesity and have the confidence and knowledge to seek advice and support.
- Training parents and carers in deprived areas in healthy cooking.

23 http://www.noo.org.uk/NOO_about_obesity/child_obesity/epidemiology

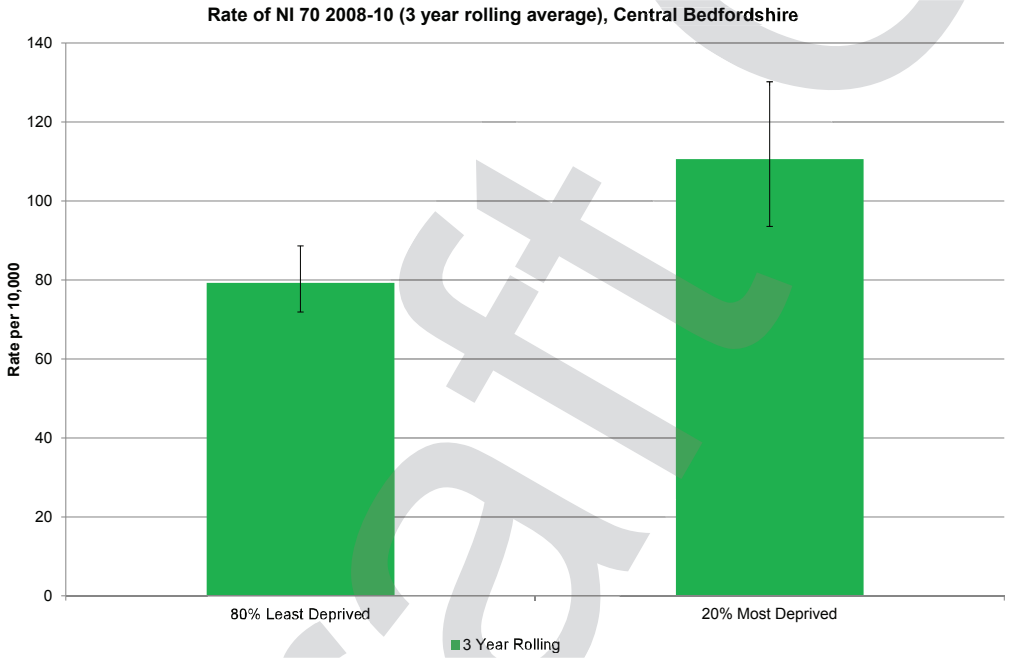
- Using social marketing to influence positive health behaviour in deprived areas.
- Introducing procedures within planning applications to monitor and potentially restrict the numbers of approvals for take-aways serving foods high in fats, sugars and salt, near schools and Children's Centres.
- Recording in full individual children's growth curves, measuring those aged 2 years and older every year to identify future risk profiles, so that interventions can be put in place as early as possible.

5.5 Injuries to children

Most injuries and their precipitating events are predictable and preventable[24], and yet unintentional injury is a leading cause of death and illness among children and young people under 14 years, and causes more children to be admitted to hospital each year than any other reason[25].

Emergency hospital admissions caused by unintentional and deliberate injuries in children and young people are grouped as national indicator number 70 (NI 70).[26] Figure 17 shows the rates (per 10,000) of emergency hospital admissions in children and young people caused by injuries. Compared to the 80% least deprived, the rate of emergency hospital admissions caused by injuries was significantly higher among children from the 20% most deprived LSOAs.

Figure 17: Rates of emergency hospital admissions caused by unintentional and deliberate injuries in children and young people (three year rolling average per 10,000 population)



Source: Hospital admission based on Secondary User Service (SUS) data, NHS Bedfordshire

24 Davis R, Pless B (2001) BMJ bans 'accidents'. Accidents are not unpredictable. British Medical Journal 322:1320–1

25 Audit Commission and Healthcare Commission (2007) Better safe than sorry: preventing unintentional injury to children. London: Audit Commission

26 Communities and local governments (2003) National Indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions: http://www.communities.gov.uk/documents/localgovernment/pdf/543055.pdf The NI 70 indicator comprises external causes of injury under International Classifications of Diseases Tenth revision (ICD-10) codes V01 to Y98, but excludes codes X33-X39 and X52 which refer to forces of nature.

Key actions

The National Institute for Health and Clinical Excellence (NICE) guidance on preventing unintentional injuries among children and young people under 15 is based on the best available evidence of what works and what gives best value for money.[27,28,29]

Recommendations cover the planning and co-ordination of programmes as well as specific interventions to improve safety on the road, in the home and at outdoor play and leisure. Priorities for the most urgent attention selected by the Accidental Injury Taskforce (2002) for children aged 0-14 years are:

- Pedestrian injuries
- Fires and thermal injuries
- Injuries from play and recreation

5.6 Teenage conceptions

Teenage pregnancy is an important public health issue because it leads to poor health and social outcomes for both teenage mothers and their children. The risk factors associated with teenage pregnancy include[30]:

- living in a deprived area;
- limited knowledge of where to access contraception and sexual health advice;
- living in care;
- alcohol and substance misuse;
- early onset of sexual activity;
- low educational attainment;
- disengagement from school;
- leaving school at 16 with no qualifications;

Teenage conceptions are measured as the rate per 1,000 females aged 15-17. The latest data for 2008-2010 shows that the rate for Central Bedfordshire is 33.3 per 1,000 girls aged 15-17. This is similar to the regional rate (30.8 per 1,000).

Teenage conception data are not released at LSOA level. The smallest areas data are provided for are wards. In 2008 – 2010, in Central Bedfordshire there were 9 wards that were teenage pregnancy 'Hotspots'[31]: These were Manshead (106), Sandy Ivel (72), Tithe Farm (73), Houghton Hall (81), Planets (59), Parkside (61), Stanbridge (56), and Northfields (70) (rates given per 1,000 females age 15-17). All except Sandy Ivel and Planets are in the 20% most deprived wards in Central Bedfordshire. Over a third of teenage conceptions occur in the deprived areas, although they only have a fifth of the population.

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27 NICE PH29 (2010). Strategies to prevent unintentional injuries among under-15s. Available via internet URL: http://guidance.nice.org.uk/PH29

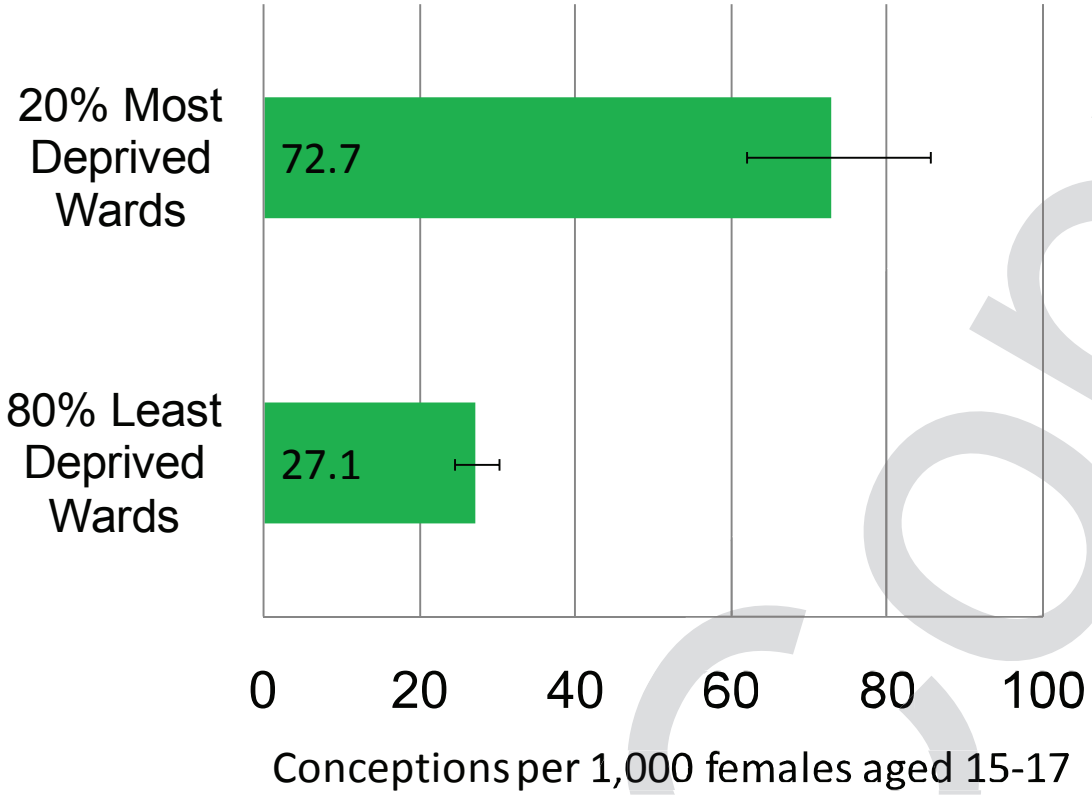
28 NICE PH30 (2010). Preventing unintentional injuries among under-15s in the home. Available via internet URL: http://guidance.nice.org.uk/PH30

29 NICE PH31 (2010). Preventing unintentional road injuries among under-15s: road design. Available via internet URL: http://guidance.nice.org.uk/PH31

30 DCSF(2006) Teenage Pregnancy Next Steps: Guidance for local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies

31 'Hotspot' wards are in the highest 20% in England with an under-18 conception rate equal or higher than 53.3 per 1000 females aged 15-17.

Figure 18: Under 18 pregnancy rates in Central Bedfordshire, 2008-10



Data source: ONS teenage pregnancy unit

Key actions

- Ensure high quality Sex and Relationships Education in schools serving deprived areas.
- Continue to provide on-site sexual health services within upper schools serving deprived areas.
- Ensure equitable access for young people to Contraceptive and Sexual Health Services (CASH).
- Raise the self-esteem, aspirations and resilience of children from deprived areas who may be disengaging from education e.g. the evidenced based Aspire programme which is being delivered at three middle schools serving teenage pregnancy "Hot-spot" wards.
- Provide specific support to the most vulnerable such as looked after children and young people not in education, employment or training (NEET) e.g. through sexual health education outreach workers who provide one to one and group work to help raise self esteem and develop decision making skills.

6 Other wider determinants of health

6.1 Educational attainment

Education is a major social determinant of health. Not only can a better level of education help to equip individuals to access greater career opportunities and income, but it can also provide the necessary knowledge, personal and social skills to access and use information and services, which in turn can maintain and improve their own and their family's health and wellbeing.[32]

Inequalities in educational outcomes affect physical and mental health, as well as income, employment and quality of life. Improving educational outcomes amongst the most disadvantaged groups has the potential to make a positive impact on health inequalities.

Where are we now

Data on inequalities in educational attainment are provided in various ways including by geographical deprivation and by eligibility for free school meals. In a deprived geographical area some children will be deprived whereas some will not. Therefore eligibility for free school meals is a stronger measure because all the children are suffering economic hardship. There is one caveat as not all children who would be eligible for free school meals claim them.

The data show that there is a gap in attainment between those known to be eligible for free school meals and those not eligible. This is true at all ages and the gap is larger than in the older age groups.

Early Years

Children's development can easily be prevented from reaching its potential when their early years' circumstances are disadvantaged. Unfortunately, by the time children start school, the effects can be so deep set that the state education system is often unable to remedy them.

Children's development at age 5 years is measured as they enter the school system and reported in the Early Years Foundation Stage Profile[33]. Provisional 2012 data shows 63% of children across Central Bedfordshire were achieving a good level of development[34], compared to 64% in England.

Provisional data for 2012 shows that for pupils known to be eligible for free school meals in Central Bedfordshire, 48% had achieved a good level of development compared with 65% who are not eligible; a gap of 17 percentage points.

32 Health Impacts of Education: a review, IPH, 2008

33 The EYFSP has 13 scales across 6 areas of development: Personal, social and emotional development; Communication, language and literacy; Problem solving, reasoning and numeracy; Knowledge and understanding of the world; Physical development; Creative Development

34 Good level of development: Those children who achieve a score of 6 or more across seven scales within 'Personal, Social and Emotional Development' (3 scales) and 'Communication, Language and Literacy' (4 scales) of the EYFSP and 78 points or more in total across all 13 scales

Education to age 11

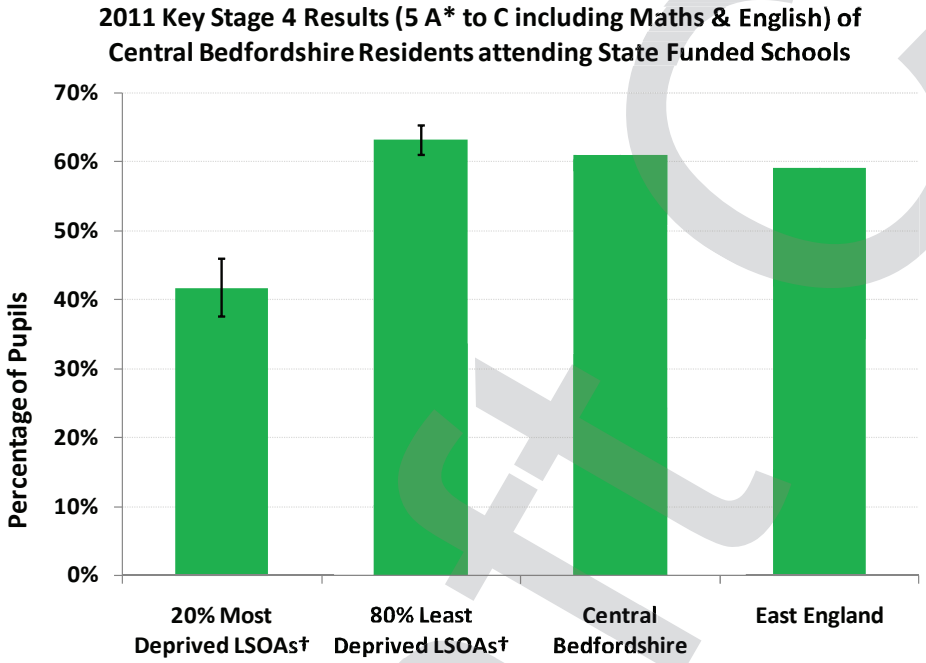
Provisional 2012 data shows 77% of Central Bedfordshire's school children achieving level 4 in English and Maths at Key Stage 2.

Provisional data for 2012 shows that of the Central Bedfordshire pupils eligible for free school meals, 57% achieved level 4 (key stage 2) in both English and Maths, compared to 78% of the non-free school meal children, a gap of 21 percentage points. The gap had only grown a little compared to the equivalent one seen at the Early Years Foundation Stage Profile.

Education to age 16

In Central Bedfordshire there is significant inequality in educational attainment at Key Stage 4 between the children from the 20% poorest areas and those from the other 80%, as shown in figure 19. In 2011, 41.6% of children from the most deprived 20% of LSOAs achieved 5 A*-C grade GCSEs including English and Mathematics, whereas 63.2% from the other 80% achieved this standard, a significant gap.

Figure 19: Central Bedfordshire Key Stage 4 Results, 2011



† Based on those LSOAs with published data. For some LSOAs, with small values, the numbers are suppressed.

In 2011 for those pupils known to be eligible for free school meals in Central Bedfordshire only 34.1% achieved 5 A*-C grade GCSEs including English and Maths, compared to 61.0% for those not eligible for free school meals – this gap of 26.9 percentage points is similar to than that seen in England of 34.7% - 62.2%.

There are also inequality gaps in achievement for Looked After Children, Gypsy/Roma and travellers of Irish Heritage and those from a Black Caribbean background (see the JSNA).

Key Actions

Helping children and young people achieve more and gain improved educational attainment are key priorities in the Children and Young People's Plan, the Child Poverty Strategy and the Council's Medium Term Plan. The key objectives and actions relating to these priorities can be found in these plans. Below is a summary of some of the actions being taken:

- Utilise Children's Centres to continue to support pre-school education, development of basic skills and early identification of poor development. They can encourage parents to be more active in pre-school learning, e.g. through encouraging play, reading to their children and help parents whose own level of education (e.g. poor literacy) act as barriers to them being engaged in their children's learning.
- Continue to provide targeted sessions at Children's Centres in areas of high deprivation. The activities should focus on all six areas of development of the Early Years Foundation Stage Profile and ensure that any children falling behind in a particular area are identified and supported.
- Ensure high quality early years intervention and prevention services are in place through Children's Centres working with parents of the very young on healthy diets, longer breastfeeding, sexual health, drugs and alcohol and stop smoking initiatives.
- Support parents and families through the parenting and family support strategy with clear pathways through to targeted parenting and family support where additional needs are identified.
- Provide multi-agency support to vulnerable families such as teenage parents where children have a 60% increased chance of being brought up in poverty.
- Ensure high quality child care is available so that parents can access training courses and opportunities to work.
- The development of a teaching school to lead good practice in Central Bedfordshire area.
- School to school support through groups of academy chains, learning partnerships and federations and a talent map of support on the Council website that schools can commission.
- Development of an alternative provision school led by head teachers for those middle and upper school age pupils who find the school environment difficult, which helps these pupils find alternative pathways to learning, training and employment and reduce permanent exclusions.
- The role of the Council as a champion for vulnerable pupils will be strongly supported.
- The role of school governors as school and community leaders will be developed.

Beyond School

According to the 2010 IMD eight LSOAs in Central Bedfordshire were within the 10% most deprived nationally in terms of education, skills and training. A further four were in the most deprived 10-20%. To address this requires education of adults as well as children. As these are also areas where the number claiming Job Seekers Allowance tends to be higher the training needs to be relevant to local employment opportunities.

Inequalities in education need to be addressed throughout life. Lifelong learning should be embedded throughout an individual's working life and should be appropriate to the needs of different groups. It should equip individuals with the skills required to take advantage of local employment opportunities.. The following actions help address inequalities:

- Promote the benefits of learning to all age groups, especially those with backgrounds of low attainment.
- The National Careers Service is an important partner which provides information for everyone. It needs to provide accessible support and advice for those from the most disadvantaged populations, on life skills, training and employment opportunities.
- Provide work-based learning, for those from deprived areas, including apprenticeships and work placements for those aged 18-24, which may be provided through Get Britain Working.
- Work related learning should be embedded throughout an individual's working life and should be appropriate to the needs of different groups and equip individuals with the skills required to take advantage of local employment opportunities

Further information is available in Central Bedfordshire's All Age Skills Strategy (http://www.centralbedfordshire.gov.uk/learning/adult-learning/all-age-skills-strategy.aspx)

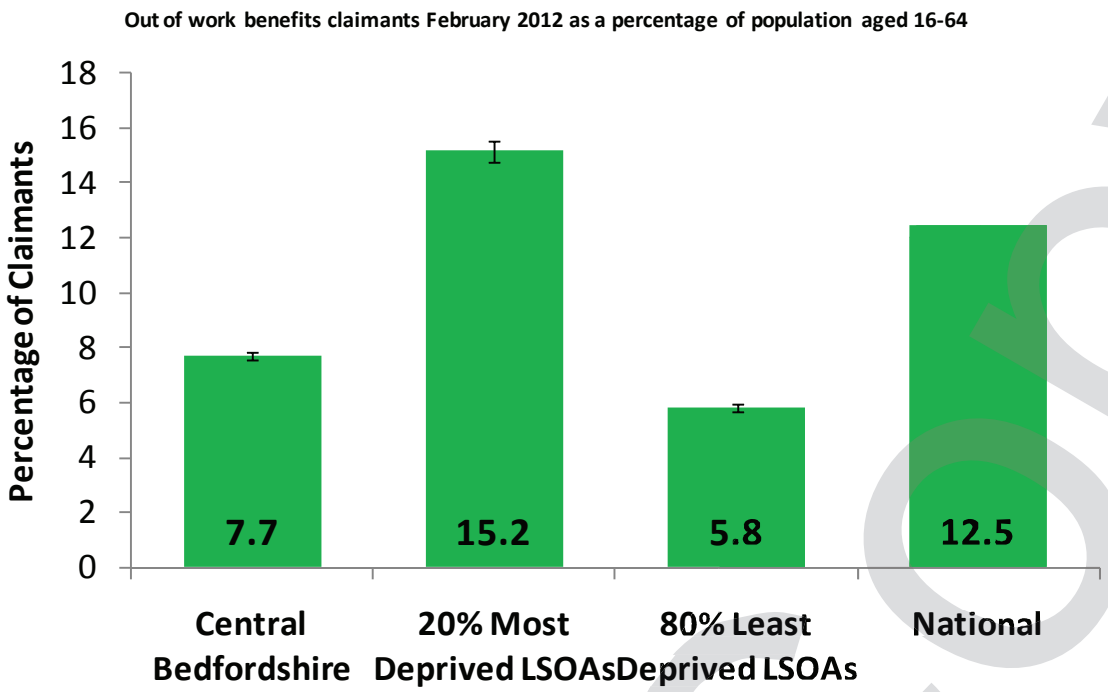
6.2 Improving employment

One area where the recent economic downturn can be expected to impact on health inequalities is through an increase in unemployment. Being in good employment is positive for your health. People are happier and live longer when they have useful work to do. Firstly it increases income, which provides better access to services and allows more healthy life choices. It increases social networks and gives a greater sense of purpose, all of which are linked to improved mental health outcomes.

However, jobs need to be sustainable and offer a decent living wage. They also need to provide opportunities for in-work development and enable a healthy work/life balance.

There are significant inequalities in employment according to where in Central Bedfordshire an individual lives, with the percentage rate of unemployed for those living in the most deprived 20% being double the overall rate for Central Bedfordshire and over 2.6 times the rate in the 80% least deprived (see figure 20).

Figure 20: Central Bedfordshire Out-of-Work Benefits Claimants February 2012



Source: Claimant count from Nomis via Central Bedfordshire Council, rates produced using population estimates from NHS registers. National is Great Britain.

The 2001 Census showed that some BME communities, particularly Chinese, White Irish and Pakistani, were more likely to have no qualifications than the overall population of Central Bedfordshire.

Raising qualifications is critical to individual employment prospects because there is a strong correlation between the highest qualification attained and the employment rate. Those with no qualifications are far less likely to be in employment. On the whole the Central Bedfordshire population is more highly qualified than the east of England and England. Also, the level of skills attainment at all levels has increased in Central Bedfordshire in each of the past four years. Those with no qualifications has halved from 14.3% to 7.2% between 2006 and 2011

Key actions

National policy will have a significant impact on employment, but local interventions are more able to reflect the level and nature of need in Central Bedfordshire, as follows:

i. Key local stakeholders, including Health and Local Authorities to provide a range of targeted tailored interventions for the workless in the most deprived areas and communities, including working in partnership with providers engaged in delivering the Department for Work and Pensions (DWP) Work Programme and Get Britain Working through:
   - Work Programme Providers, Job Centre Plus, etc. to ensure interventions target those in the most deprived areas and communities.
   - Accurate assessment of individual needs and clear signposting to appropriate interventions.

- Support for those whose mental and physical health needs prevent sustainable working.
- Provision of volunteering opportunities.

ii. Key local agencies to work closely with European Social Fund (ESF) and Get Britain Working providers to:
   - Encourage awareness and utilisation of provision, including the regional Skills Support for the Unemployed Programme and local projects targeting, for example, those with work limiting illnesses and Gypsies and Travellers.
   - Encourage self-employment, through Enterprise Coaching and Get Britain Working measures (e.g. New Enterprise Allowance and Enterprise Clubs).
   - Promote volunteering, through ESF provision and Get Britain Working – both as a means of gaining employability skills and also for its wider social benefits.

iii. The Local Authority and partners to work together to improve the support available to existing businesses, and to potential inward investors to encourage job creation.

iv. The Local Authority and partners to work with training providers and support organisations to ensure programmes equip workless individuals with the skills and experience required for existing and emerging employment opportunities. For example, work clubs are running across Central Bedfordshire.

v. Improved opportunities to be provided for young people who are Not in Education, Employment or Training (NEET) by encouraging the take-up of tailored support offered through local ESF projects for those currently NEET and those deemed at risk of becoming NEET.

Further information about the local economy is available: http://www.centralbedfordshire.gov.uk/local-business/business-information-and-advice/local-economic-information-policy.aspx

6.3 Housing

Housing conditions affect people's health. Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases, cancer and poor mental health.

The locally commissioned Housing Stock Modelling Report estimated that over a quarter (28%) of private sector dwellings in Central Bedfordshire fail to meet the Decent Homes Standard[35] compared to 36% in England as a whole. The main reason for failing the decent homes standard is the presence of a category 1 hazard. Around a fifth of all private homes in Central Bedfordshire contain at least one category 1 hazard. Category 1 hazards include: excess cold; falls on the level and on stairs; entry by intruders; flames and hot surfaces; damp and mould growth and fire.

Excess cold was the most frequent category 1 hazard (55%) followed by risk of falls (41.6%). Note, a dwelling may have more than one hazard. What is clear is that poor thermal comfort and excess cold are key issues, with 11% -12% of all private homes having these problems.

35 Under the 2004 Housing Act the Housing Health and Safety Rating System

Wards (pre June 2009) with high proportions of non-decent homes include:

Aspley Guise	-	42%
Houghton Conquest	-	39%
Northill and Blunham	-	38%
Woburn	-	47%
Caddington	-	37%
Kensworth and Totternhoe	-	43%
Stanbridge	-	43%

Wards (pre June 2009) with high numbers of non-decent homes include:

Caddington	-	912
Kensworth and Totternhoe	-	718
Potton and Wensley	-	794
Dunstable Central	-	654
Ampthill	-	649

There are an estimated 11,000 vulnerable households in Central Bedfordshire, 28% of these live in non-decent homes. This is an improvement on previous years.

Key Actions

- Identify households at greatest risk – i.e. those in receipt of means-tested benefits and households with older people and/or people with disabilities – paying particular attention to certain geographic communities.
- Initiate appropriate action where Category 1 Hazards are found
- Continue investment to bring all households up to the 'Decent Homes' standard.
- Work in partnership with private landlords to improve housing standards in the private rented sector (for example Property Accreditation)
- Identify houses with multiple occupancy.
- Provide smoke alarms to members of vulnerable communities.
- Tackle fuel poverty (see below).
- Obtain and analyse new data sources to improve targeting of resources

6.4 Fuel Poverty

Households are considered to be in fuel poverty if more than 10% of their net household income would need to be spent on heating and hot water to give an adequate level of provision. With energy costs continuing to increase, the number of households in fuel poverty will also increase. Approximately 16% of households in Central Bedfordshire are currently affected by fuel poverty due to recent price rises. Fuel poverty is usually associated with dwellings where one or more residents are in receipt of a means-tested benefit.

Older people are more likely to suffer from fuel poverty. Over one third of those households where the oldest person is aged over 80 are affected by fuel poverty. Households with older people are more likely to have lower incomes and have higher fuel dependency.

Fuel poverty tends to be more of an issue in rural areas, and those areas with high levels of private rented accommodation. In Central Bedfordshire, four LSOAs are in the worst 20% in England for fuel poverty. The first area covers part of Woburn, plus Potsgrove, Battlesden, Milton Bryan, Ridgmont and Eversholt. The other three areas are in Houghton Regis, Cranfield (covering the university) and Southill and Old Warden.

Key Actions

Improve the energy efficiency of housing (this also reduces carbon emissions) and support households in fuel poverty by:

- Requiring agencies with workers who go into private homes to identify where individuals may be in fuel poverty.
- Providing signposting and information to enable people to take up energy grants.
- Providing effective advocacy to support vulnerable people to take up energy grants.
- Identifying and pursuing all opportunities to utilise external resources to tackle fuel poverty in a co-ordinated, partnership approach. This would be led by the council.

6.5 Excess winter deaths

Excess winter deaths continue to be an important public health problem. It is estimated that half of the excess winter deaths are from cardiovascular and circulatory diseases and a third from respiratory disease. The excess winter deaths index (EWDI) is the number of excess winter (December to March) deaths expressed as a percentage of the average of non-winter deaths.

Excess winter deaths are most commonly seen in those aged 65 years and over and especially affect those aged 85 and over. A history of respiratory disease is also a risk factor.

There is lack of a clear link between excess winter mortality and deprivation, due to the inclusion of heating costs within the rent for people in council and housing association owned properties.

Key Actions

Focussing particularly on the elderly, very elderly and those with a history of respiratory disease:

- Tackle fuel poverty (see above).
- Ensure influenza vaccination is taken up as about 5% of excess winter deaths are caused by 'flu.

6.6 Sustainable development

The Marmot Review 'Fair Society, Health Lives' recognises that, globally, climate change and attempts to combat it have the worst effects on the poorest and most vulnerable. The need for mitigation of and adaptation to climate change means that we must do things differently. Creating a sustainable future is entirely compatible with action to reduce health inequalities. Sustainable local communities, active transport, sustainable food production, and zero-carbon houses will have health benefits across society. Measures that will aid mitigation of climate change will also reduce health inequalities[36].

36 The Marmot Review 2010, *Fair Society, Healthy Lives*.

The Marmot Review makes recommendations to address the need for a sustainable economy, food system, transport systems, and use of green spaces. Many measures to address climate change also bring health benefits such as more active travel (for instance walking and cycling), which, in addition to reducing carbon emissions, also increase physical activity and reduce air pollution and traffic accidents.

Key actions

To encourage sustainable development, Central Bedfordshire should prioritise policies and interventions that both reduce health inequalities and mitigate climate change across the social gradient by:

- Improving active travel
- Improving availability of good quality open spaces
- Improving the food environment in local areas
- Improving energy efficiency in housing

7 Conclusions

There are significant economic and health inequalities in Central Bedfordshire. Although inequality in life expectancy is better than England there is a significant and growing gap between the 20% most deprived and the rest of the population. The gap is widening because life expectancy in the deprived 20% is static but in the other 80% it is improving year on year.

This report has summarised actions to tackle specific health inequalities in Central Bedfordshire such as: low breastfeeding rates; childhood obesity; teenage conceptions and smoking; and the drivers of inequality such as low education attainment and unemployment. Chronic diseases such as circulatory diseases, cancers and respiratory diseases are significant contributors to the life expectancy gap.

To tackle health inequalities we need to focus on wider social and economic inequalities as advocated by the Marmot Review. Giving every child the best start in life is a priority. This approach provides the best chance of breaking the links between early disadvantage and poor outcomes throughout life.

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Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Central Bedfordshire LINk Report
Meeting Date:	31 January 2013
Responsible Officer(s)	Charlotte Bonser (LINk Operations Manager)
Presented by:	Bob Smith, Chairman of LINk

Action Required: The Board is asked to:

1. Receive the Overview Report on Enter and View to Six Care/Nursing Homes in Central Bedfordshire .

2. Note LINks contribution to the emerging Central Bedfordshire Healthwatch.

Executive Summary	
1.	To present an Overview Report of its Enter and View Project to six Care/Nursing Homes in Central Bedfordshire (**Appendix A).** To highlight LINk's involvement in developing Central Bedfordshire Healthwatch.

Background	
2.	The above two areas were key tasks within the LINk's 2012-13 work plan. Following the completion of the Enter and View Project to six Care/Nursing Homes in Central Bedfordshire in October 2012, the LINk Project Group met to review their work on 20 November. **Appendix A** represents an overview report of the project indicating the aims of the project, main activities, findings, recommendations, conclusions and overall legacy as we move towards Healthwatch.
3.	The reports have been shared with both the Central Bedfordshire Social Care, Health and Housing Compliance Team and the Care Quality Commission and can be accessed on the LINk website at www.bedfordshirelink.co.uk

4.	At a meeting in November 2012, Maggie Hannelly, CQC Compliance Manager, indicated that the LINk reports had been shared with CQC inspectors and that the report would be considered when undertaking the next round of inspections and that the report had been favourably received by the CQC Inspectors.
5.	The LINk continues to be involved in the development of Central Bedfordshire Healthwatch through its participation in the Healthwatch Pathfinder meetings with colleagues from the voluntary and community sector, NHS and the Council..
6.	The LINk contributed to the joint submission with the Council to become a Pathfinder Healthwatch and is keen to see the establishment of a Healthwatch organisation that involves the third sector, patient participation groups and partners supporting Healthwatch.

Preparing for Healthwatch and patient and public engagement across social care and health	
7.	The LINK legacy report, shared with the Pathfinder Healthwatch group, stressed the importance of communication and raising awareness of Healthwatch as widely as possible. It also highlighted the importance of the volunteer base to the success of Healthwatch and the need to continue to involve, engage and develop the existing active LINk membership as well as recruiting new participants.
8.	The LINk has shown how its current structure of gathering information through the recording of incidents and working through issues within its working groups in health, social care and mental health and learning disabilities has been successful. It has also demonstrated the ability to develop its own training for members in enter and view visits to all health and social care bases, and hopes the new Central Bedfordshire Healthwatch will build on these skills as it evolves.
9.	There is some concern regarding where the linkages between Healthwatch and the lay / patient representative structure established by the Clinical Commissioning Group as LINk has been advised that following the appointment of a lay representative, its participation on the Board of the Clinical Commissioning Group is no longer required
10.	The LINk would welcome some clarification on the relationship between the BCCG, Healthwatch Central Bedfordshire and the Lay Representative to support the delivery of BCCG's commitment to engage with patients and the public.

Issues	
Strategy Implications	
11	LINk's work is aligned to the Health and Well Being Strategy in terms of improving outcomes for the most vulnerable and is an advocate for early intervention and prevention in terms of health and well being.
12.	The objectives in the LINk report are in line with the main themes within the JSNA and the BCCG strategy.
Governance & Delivery	
13.	Central Bedfordshire Council is responsible for contracting support arrangements for the independent LINk. Central Bedfordshire is responsible for commissioning Healthwatch under the Health and Social Care Act 2012.
Management Responsibility	
14.	Central Bedfordshire Council is responsible for contracting support arrangements that enables the work of the independent LINk which is overseen by the LINk Board.
15.	Commissioning Healthwatch Central Bedfordshire is a duty for the Local Authority under the Health and Social Care Act 2012. Management of this process is via a multi-agency Steering Group which also is responsible for leading the development of Healthwatch Central Bedfordshire. Updates on progress on commissioning Healthwatch to the Health and Well Being Board will be through the Director of Social Care, Health and Housing.
Public Sector Equality Duty (PSED)	
16.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty Yes
	No Yes *Please describe in risk analysis*

Risk Analysis
In undertaking enter and view visits to health and social care bases, eg. Hospital wards, care homes, GP surgeries, members must act with due regard to the day-to-day operations of these bases, in terms of respecting the staff, patients and residents of those premises and having due regard to equality issues.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**
Enter & View Visits	Low	High	Training and development carried out as required. This will include training in equality and diversity issues taking into account Public Sector Equality Duties.

Source Documents	**Location (including url where possible)**

Presented by Bob Smith

Bedfordshire LINk (covering central Bedfordshire)

Enter and View Project Task Group Overview Report.

Report Author
Graham Abdullah Dinn
Social Care Working Group and Project Lead

Date
December 2012

1. Introduction

The main aim of Bedfordshire LINk Social Care Working Group Enter and View Project Task Group was:
To devise and implement a Bedfordshire LINk project plan in order for (announced) Enter and View Visits to be carried out within six Care/Nursing Homes across Central Bedfordshire by voluntary members of Bedfordshire LINk.

The project membership consisted of nine Bedfordshire LINk Social Care Working Group volunteers and one member originally from the host organisation Voluntary Action Luton, which later was hosted by Central Bedfordshire Council. The project was completed over a 12 month period from November 2011-November 2012.

This report will provide a summary of the main areas of activity identified within the project plan, the outcomes and legacy.

2. Main activities of the project plan

The project group members identified seven main activities for inclusion within the project plan which were all successfully completed. These were:

- The mapping of existing documents/information relating to care/nursing home enter and view visits
- Internal and external communication methods to be utilised in order to provide details of the project and to encourage other Bedfordshire Link volunteers to participate
- To produce project terms of reference and submit these to Bedfordshire LINk board for approval
- Produce a schedule of announced enter and view visits for six care/nursing homes
- Set out the policy/procedures within generic guidelines and design the reporting format to complete the care/nursing home visits
- Design and deliver (one day) enter and view training so that volunteers can act as Bedfordshire LINk authorised representatives
- Complete the announced enter and view visits and an overview project report.

3. Main outcomes from the enter and view announced care/nursing home visits

3.1 Schedule of announced enter and view visits

Enter and view visits were completed within six care/nursing homes as follows:

a) Woodside Residential Care Home, Slip End, Luton, visited on 17.08.12
b) The Paddocks, Wellhead, visited on 23.08.12
c) Greenacres Care Home, Dunstable, visited on 14.09.12
d) Meppershall Care Home, Meppershall, visited on 17.09.12
e) Swiss Cottage Care Home, Leighton Buzzard, visited on 03.10.12
f) Ridgeway Lodge Care Home, Dunstable, visited on 16.10.12

In line with the Bedfordshire LINk enter and view visit guidelines designed by the project members, each home was visited by two volunteers who produced a report at the end of each visit. The duration of the visits was variable from a minimum of 1.45

hours for a small home of 10 people to a maximum of 4.10 hours for a large care/nursing home with 85 rooms.

3.2 Best practice and person centred care
During the enter and view visits to each home, the two authorised representatives were also looking for evidence of the application by the staff of best practice relating to person centred care. This is defined within the Care Quality Commission (November 2012) report the state of health care and adult social care in England in 2011/12 as:

"Those services that apply person centred care and maintain people's dignity and treat them with respect all have the following in common:

- They recognise the individuality of each person in their care
- They help them to retain their sense of identity and self-worth
- Take time to listen to what people say
- Are alert to people's emotional needs as much as their physical needs
- Give people more control over their care and the environment around them (p 10)

On the other hand, across the social care sector, the following is applicable for those services that do not maintain people's dignity or treat them with repect:

- Care staff talking over the person, as if they were not there
- Having things done to them, rather than with them
- Getting people ready for bed at a time that suits the staff rather than the individual person being cared for (p 11).

4. Main outcomes and findings of the visits
We saw evidence of good disabled access and care being provided within the majority of the homes visited.

4.1 Dignity, privacy of residents and best practice methods
During some of the enter and view visits we also observed evidence of how the homes staff treated the residents with dignity and applied strategies to ensure their privacy was respected. Some examples included having a choice to have their own room door keys, staff knocking before entering residents' rooms, allowing residents to get themselves to the table to sit down for lunch (a & f)

However, within one home we noted that on one floor most bedroom doors were open whether occupied or not, and we were unsure of the reason for this; ease of access at the time period we visited or part of the practice within the home (c).

We noted how staff had time to pay respectful and affectionate attention to residents and involved them within day to day household tasks within one small home (b)

There was also some examples evidencing use of best practice methods, such as the use of notice boards with key information and pictures of food, reminiscence techniques such as family history albums, use of memory boxes and pictures outside each resident's room, visit by the Salvation Army band for a sing-along session and the use of the QUEST system or the monitoring of the residents food intake, care planning with a designated key worker (a, b, c, e & f).

4.2 Cleanliness of homes
Generally the areas within the homes that we visited were clean and did not have undue odours (a, b, c, d, e & f)

4.3 Procedures for medication, security of residents and food
The food that was produced for lunch, observed within some of the homes, was appetising with the residents having some choices on the food that they could request (a & f)

Systems were in place for the administration of medication and security (a, b, c, d & f)

4.4 Resident's social, recreational and other activities
All the homes visited tended to provide a range of services and activities available for the residents within the homes with some opportunities to participate in external activities (some examples included, watching TV, physiotherapy, Film Afternoon, Movement and Music, Memory Clinic attending a stroke club, shopping, going out for lunch).

4.5 Opportunities to practice faith and external activities
We also noted some evidence that for those residents who wanted to, there were opportunities to practise their individual faith (examples, attending internal and external religious services, quite room (a, c, d, e, e & f))

4.6 Staffing numbers, training and qualifications
A minimum of 2 staff tended to be working (a, b, c & f) with one of the duty managers having a nursing qualification (a & d)

We noted within a number of the homes that the staff had either been trained or were continuing to complete training in relation to the relevant core (examples, SOVA, Medicines, Moving and Handling, Dementia) and relevant qualifications for the senior staff (a, b, c, d, e & f)

4.7 Residents, carers and family comments
The residents, their carers and family that we spoke with, generally made positive comments upon the homes and the services that they provided (a, c, d & f), for example "I like it here, I have made friends…I have spoken to the staff and they were helpful" (relating to concerns as to what might happen if the resident's money ran out)(f))

However, on some occasions, some residents commented upon other issues they wished to raise relating to the staff such as staff morale which can be paraphrased as; "New company have sent in two trouble shooters to lift the place…staff morale is poor…". Another resident within the same home pointed out that "…her life would be in danger" if she was to tell the two authorised representatives all the things that were wrong with the home (e).

4.8 Staff comments
The majority of the staff we spoke to made positive comments upon the homes they worked within (a, b, c, d & f), a typical comment was “I enjoy working here” (f)

During our visits we also encountered comments from staff relating to their concerns. The staff within one home stated they sometimes encountered difficulties with the GP surgery when requesting a GP visit to a resident (a). Within another home the staff felt that when staff members ring in sick there would “not sufficient staff to bring in to cover”, they felt understaffed. Furthermore they pointed out that they had staff meetings but “felt nothing was carried out following these”. They worried that this would have a detrimental effect on residents’ care (e).

These staff concerns relating to staff morale were also raised by one of the residents. At the end of the visit the two LINk authorised representatives were informed by that the new owners have made recruitment a priority (e).

4.9 Report recommendations
The enter and view visits to the six care/nursing homes resulted in a variety of recommendations being made by the Bedfordshire LINk authorised representatives within their reports. Some of these recommendations now follow.

“Home owners to go ahead with their plans to update their website to provide more information. Following the building refurbishment and commencement of the new registration as a residential/nursing care home another visit to take place by Bedfordshire LINk or Healthwatch in one year’s time.” (a)

“There does need to be a need for extra space, perhaps a room for the use of residents” (use for quiet activities such as reading/conversations (b)).

“We would like to see more space for general activities which seem to have been lost when the step up/step down unit took over the large day centre (c)
Attention required to electrical wiring on floor arrears, possible falls hazard. One communal toilet had a broken plastic toilet roll holder. Within some locations, self-adhesive signs on doors become detached” (d).

“The host may need to seek clarification in respect of comments and concerns raised by residents during our visit. Structured supervision, continued training, clearer consultation to lift low morale (needs to be implemented). Following completion of refurbishment and inspection by CQC another visit form Bedfordshire LINk or Healthwatch within the next 12 months” (e).

“The manager should address one resident’s choice on his personal plan for a male care assistant to provide personal care. Another visit takes place by Bedfordshire LINk or Healthwatch in one years’ time” (f).

4.10 Management and leadership
Within two of the homes (a & e) we identified the impact and importance the role of good leadership and management played on staff morale and the application of good person centred care for the residents. Indeed the Care Quality Commission (March 2012) Review of Compliance report points out that on their previous visit in Feb 11

there were 12 outcomes needing improvement. However, following their 2012 visit the home was compliant within all the outcomes and they "were told that the care provided…has improved considerably since the current manager took up post at the end of 2010" (a).

The importance of good leadership and management is also identified within the Care Quality Commission (November 2012) The state of health care and adult social care in England in 2011/12 report which points out that:
"In a number of social care settings, CQC's inspectors have found poor managers in place, or even the absence of a manager…very often, a change of registered manager following action by CQC was the impetus for dramatic changes in the quality of care provided" (page 11).

4.11 Financial sustainability
One of the homes that we visited had 9 residents within the 27 roomed home, which meant that 18 rooms were vacant. We were informed by the manager that recently they had successfully registered with the Care Quality Commission to become a Nursing and Residential Care Home from August 2012 with an increase in room capacity following refurbishment (a). One point to note here is that there is no guarantee that this home will be able to fill sufficient rooms to ensure its financial sustainability and, importantly, the residents' home.

The Care Minister Norman Lamb stated on the BBC (01.12.12) that; "we want to make sure every person receiving care and support will continue to get the care they need if a provider exits the market, regardless of whether they are paid for by the state or pay for care themselves."

He also points out the collapse of Southern Cross showed the need for "greater oversight of provider's finances" by the regulator such as the Care Quality Commission.

5. Project Review/End of Project Workshop
As part of the project plan, a half a day project review/end of project workshop was completed on the 20.11.2012. The main aims of this workshop were to review the process, documents used such as the reporting template and obtain the opinions of the volunteers on their experiences.

Generally the members of the project felt that the whole process had been successful although fairly lengthy in taking 12 months to complete.

The participants of the workshop also felt that the project had been useful and had helped them to understand the current standards of care in these homes. Members felt that in all the homes they had visited they had observed evidence of how the staff treated the residents with dignity and applied strategies to ensure their privacy was respected.

One workshop participant said that it had been a humbling experience to see some residents in varying stages of dementia. Another member stated that they felt empowered in being able to design and deliver enter and view training to other volunteers. There was concern in some cases of the isolation faced by residents

who were mentally and physically able to be involved in social activities, but either there was little available or their perception was that they would not be allowed to do something,(for example, have a beer) One suggestion was that this could be an area in which other voluntary organisations might be able to assist the residents within the homes who wished to with internal and external activities. However, on the whole most residents appeared to be content with their care.

Staffing levels seemed to be an issue within some of the care/nursing homes visited, and the experience and aptitude of the home manager appears to contribute to how happy residents seemed on the day and in creating a good living environment. Members of the project felt that is might be useful to obtain a better understanding upon the compulsory training that was required by care home staff and other short courses that they completed. Members expressed the opinion that the care/nursing home staff training should also include falls prevention.

There was also a general consensus by the project group members that home staff training should also include the care relationships with residents. The Chief Nursing Officer for England, Jane Cummings, has recently launched a three year Compassion in Practice strategy for nursing. According to Professor of Geriatric Medicine Peter Crome from Keele University this is aimed at nurses and other care staff "taking a more caring and compassionate role…rather than what is often seen as a very task-orientated approach." (BBC Radio 4's Today Programme 04.12.2012).

All the members of the project found it useful to obtain information on the home prior to the visit, including finding out the exact location in order to arrive on time for the announced visit. The workshop participants felt that the project group had done a lot of the ground work, so that within future enter and view visits the organisation and progression of the visits should be easier.

6. Overall legacy

The main legacy of this enter and view project task group is that 10 volunteers participated and gained experience of being part of a project and in completing six enter and view visits and care/nursing home reports. Some 6 volunteers now have experience of designing and acting as facilitators/trainers for a one day enter and view training course.

The project group have developed care nursing home reporting template and generic Bedfordshire LINk enter and view guidelines for use by all its volunteers. Other care/nursing homes have been identified as requiring visits to be completed within them.

7. Conclusions

The 12 month project was successful and achieved all the aims and objectives that were identified within the project plan.

There was evidence of best practice good care being provided for the residents within the majority of the home visited. The Bedfordshire LINk authorised representatives whom completed enter and view visits also identified issues pertaining to low staff moral and the impact that good leadership and management had upon the application by staff of person centred care.

The future financial sustainability and, importantly, the need to ensure security of the residents' home, was identified as a potential issue within one home.

Some thought needs to be given to how the work associated with the project and the experience that the voluntary project members have gained can be transferred into the new local Central Bedfordshire Healthwatch.

Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	**Board Development and Work plan 2013 -2014**
Meeting Date:	31 January 2013
Responsible Officer(s)	Richard Carr
Presented by:	Richard Carr

Action Required: That the shadow Health and Wellbeing Board:

1. considers and approves the work plan attached, subject to any further amendments it may wish to make.

Executive Summary	
1.	To present an updated work programme of items for the Health and Well Being Board for 2013 -2014.

Background	
2.	Health and Wellbeing Boards are a requirement under the Health and Social Care Act 2012. The Board brings together key local commissioners for health, social care and public health. It provides strategic leadership and will promote integration across health and adult social care, children's services, safeguarding and the wider local authority to secure high quality and equitable health and wellbeing outcomes for the population of Central Bedfordshire.
3.	The Work Plan is designed to ensure the Health and Wellbeing Board is able to deliver its the statutory responsibilities and key projects that have been identified as priorities by the Board.

Work Programme	
4.	Attached at Appendix A is the currently drafted work programme for the Board.
5.	The Board is now requested to consider the work programme attached and amend or add to it as necessary. This will allow officers to plan accordingly but will not preclude further items being added during the course of the year if Members so wish and capacity exists.

6.	Attached at Appendix B is a form to be completed to add items to the work programme.

Issues	
Strategy Implications	
1.	The Health and Wellbeing Board is responsible for the Health and Wellbeing Strategy. The work plan contributes to the delivery of priorities of the strategy,
2.	The Work plan includes key strategies of the Clinical Commissioning Group.
Governance & Delivery	
3.	The work plan takes account the duties set out the Health and Social Care Act 2012 and will be carried forward when the Board assumes statutory powers from April 2013.
Management Responsibility	
4.	The Chief Executive of Central Bedfordshire Council is responsible for work plan and development of the Health and Wellbeing Board.
Public Sector Equality Duty (PSED)	
5.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
	Are there any risks issues relating Public Sector Equality Duty Yes/No
	No Yes *Please describe in risk analysis*

Risk Analysis
A forward work plan ensures that the Health and Wellbeing Board remains focused on key priorities areas and activities to deliver improved outcomes for the people of Central Bedfordshire.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Appendices:
A – Shadow Health and Wellbeing Board Work Programme
B – Item request form for Shadow Health and Wellbeing Board Work Programme

Source Documents	Location (including url where possible)

Presented by Richard Carr

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Appendix A

Work Programme for Shadow Health and Wellbeing Board

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
1.	Improving outcomes for Frail Older People	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy, including the outcome of the Community Beds Review.	21 March 2013	Report	Julie Ogley (Director of Adult Social Care, Health and Housing, CBC) Dr Diane Gray (Director of Strategy and System Redesign, BCCG)
2.	Improving mental health and wellbeing of adults	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy. This will also provide an update on the work that BCCG has been progressing around the vision for the future of Mental Health Services to determine commissioning priorities.	21 March 2013	Report	Dr Diane Gray (Director of Strategy and System Redesign, BCCG)
3.	Presentation on the implications for high dependency children and young people of the special educational needs reforms.	To consider and comment on this new policy area.	21 March 2013	Presentation	Edwina Grant (Deputy Chief Executive and Director of Children's Services, CBC)

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
4.	Health and Wellbeing Board becoming a formal Committee of the Council Assumption of Statutory Powers	To receive a paper setting out the statutory powers and constitutional implications of the Health and Wellbeing Board as a formal committee of Central Bedfordshire Council Health and Wellbeing Boards will assume statutory powers from April 2013.	21 March 2013		JA?
5.	Work Programme	To consider and approve the work plan A forward work plan ensures that the Health and Wellbeing Board remains focused on key priorities areas and activities to deliver improved outcomes for the people of Central Bedfordshire.	21 March 2013		Richard Carr (Chief Executive, CBC)
6.	Report from LINk / HealthWatch	To receive a report on LINK/Healthwatch activity	21 March 2013		Bob Smith (Chairman Bedfordshire LINk)
7.	Annual Assessment of CCGs	To receive a report on the annual assessment process for the CCG	21 March 2013		John Rooke (Chief Operating Officer, BCCG)
8.	Promoting Independence and Choice	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	9 May 2013		Julie Ogley (Director of Adult Social Care, Health and Housing, CBC) Contact officer: Stuart Rees, AD Adult Social Care
9.	Helping people to make healthy lifestyle choices	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	9 May 2013		Muriel Scott (Director of Public Health) Contact Officer: Celia Shohet, AD Public Health

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
10.	Safeguarding and Patient Safety	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	18th July 2013		Julie Ogley (Director of Adult Social Care, Health and Housing, CBC) Anne Murray (Director of Quality and Safety, BCCG) Contact Officers: Emily White (Safeguarding Vulnerable Adults Manager, CBC) and Clare Sanders (Deputy Director, BCCG)
11.	Improving mental health for children and their parents	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	18th July 2013		Dr Diane Gray (Director of Strategy and System Redesign, BCCG) Contact Officer: Jane Hainstock (Head of Partnership Commissioning, BCCG)
12.	Reducing Teenage Pregnancy	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	5th September 2013		Muriel Scott (Director of Public Health) Contact Officer: Celia Shohet, AD Public Health
13.	Improving the health of Looked After Children	To receive and comment upon the current position and progress towards delivering this priority within the Joint Health and Wellbeing Strategy.	24th October 2013		Anne Murray (Director of Quality and Safety, BCCG) Contact Officer: Clare Sanders (Deputy Director, BCCG)
14.	Reducing Childhood	To receive and comment upon the current position and progress towards delivering this	19th		Muriel Scott (Director of Public

Ref	Issue for Decision	Intended Decision	Indicative Meeting Date	Documents which may be considered	Contact Officer (method of comment and closing date)
	Obesity	priority within the Joint Health and Wellbeing Strategy.	December 2013		Health) Contact Officer: Celia Shohet, AD Public Health

Shadow Health and Wellbeing Board

Work Programme of Decisions

Title of report and intended decision to be agreed by the Shadow HWB	Indicative Meeting Date	Consultees and Date/Method	Documents which may be considered	Contact Members and Officers (Method of Comment and Closing Date)
Insert the title of the key decision and a short sentence describing what decision the Shadow HWB will need to make e.g. To adopt ……	Insert the date of the Shadow HWB meeting	Insert who has been consulted e.g. stakeholders, the date they were consulted and the method.	Insert the documents the Shadow HWB may consider when making their decision e.g. report.	Insert the name and title of the relevant Shadow HWB Member, the name of the relevant Director and the name, telephone number and email address of the contact officer. Also insert the closing date for comments, if no date is supplied, then the closing date will be a month before the Shadow HWB date e.g. the closing date for the Shadow HWB meeting on 8 November will be 11 October.

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